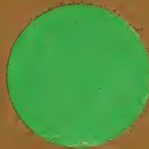


**LEGISLATIVE HISTORY
TITLES I-XX
OF THE
SOCIAL SECURITY ACT**

**Volume XXIV
101st Congress
1989-1990**

Part 3



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**Legislative History of
Titles I-XX
of the Social Security Act**

**Volume XXIV
101st Congress
1989-1990**

Part 3

**Compiled by the
Technical Documents Branch
Division of Technical Documents and Privacy
Office of Regulations
Office of Policy
Social Security Administration**

OMNIBUS BUDGET RECONCILIATION ACT
OF 1990

R E P O R T

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 5835

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 4 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR THE FISCAL YEAR 1991

together with

ADDITIONAL, MINORITY, AND DISSENTING VIEWS



OCTOBER 16 (legislative day, OCTOBER 15), 1990.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

CONTENTS

	Page
Statement of the Committee on the Budget	1
Reporting of the Bill	1
Title I—Committee on Agriculture:	
Letter of Transmittal	3
Report to Accompany Recommendations from the Committee on Agriculture	3
Title II—Committee on Banking, Finance and Urban Affairs:	
Letter of Transmittal	17
Report to Accompany Recommendations from the Committee on Banking, Finance and Urban Affairs	17
CBO Cost Estimates	31
Title III—Committee on Education and Labor:	
Letter of Transmittal	35
Report to Accompany Recommendations from the Committee on Education and Labor	35
CBO Cost Estimates	60
Title IV—Committee on Energy and Commerce:	
Letter of Transmittal	63
Report to Accompany Recommendations from the Committee on Energy and Commerce	63
CBO Cost Estimates	67
Title V—Committee on Interior and Insular Affairs:	
Letter of Transmittal	153
Report to Accompany Recommendations from the Committee on Interior and Insular Affairs	153
CBO Cost Estimates	154
Title VI—Committee on Judiciary:	
Letter of Transmittal	159
Report to Accompany Recommendations from the Committee on Judiciary	159
CBO Cost Estimates	162
Title VII—Committee on Merchant Marine and Fisheries:	
Letter of Transmittal	163
Report to Accompany Recommendations from the Committee on Merchant Marine and Fisheries	164
CBO Cost Estimates	167
Title VIII—Committee on Post Office and Civil Service:	
Letter of Transmittal	169
Report to Accompany Recommendations from the Committee on Post Office and Civil Service	174
CBO Cost Estimates	195
Title IX—Committee on Public Works and Transportation:	
Letter of Transmittal	199
Report to Accompany Recommendations from the Committee on Public Works and Transportation	199
CBO Cost Estimates	205
Title X—Committee on Science, Space, and Technology:	
Letter of Transmittal	209
Report to Accompany Recommendations from the Committee on Science, Space, and Technology	209
CBO Cost Estimates	215
Title XI—Committee on Veterans' Affairs:	
Letter of Transmittal	217

IV

	Page
Title XI—Committee on Veterans' Affairs—Continued	
Report to Accompany Recommendations from the Committee on Veterans' Affairs	217
CBO Cost Estimates	223
Title XII and XIII—Ways and Means:	
Letter of Transmittal.....	225
Report to Accompany Recommendations from the Committee on Ways and Means.....	229
CBO Cost Estimates	368
Additional Views.....	371

TITLE IV—COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC, October 15, 1990.

HON. LEON E. PANETTA,
*Chairman, Committee on the Budget,
House of Representatives, Washington, D.C. 20515*

DEAR MR. CHAIRMAN: I am transmitting herewith the recommendation of the Committee on Energy and Commerce for changes in laws within its jurisdiction pursuant to section 310 of the Congressional Budget Act of 1974 and section 4(b)(4) of H. Con. Res. 310, the Concurrent Resolution on the Budget-Fiscal Year 1991.

The recommendations are embodied in a series of Committee prints adopted by the Committee on October 11, 1990 and reflected in Subtitles A through C of the enclosed statutory language. Also enclosed is accompanying report language and Congressional Budget Office cost estimates.

The enclosed recommendations, when combined with non-duplicative savings achieved in Medicare by the Committee on Ways and Means, and the EPA fees shared with the Committees on Public Works and Agriculture, will meet or exceed budget resolution targets for this Committee.

The Committee has received assurances from the Budget Committee that we will be credited with savings with respect to three provisions which have already been acted on by the House.

First, the automobile fees referenced in Subtitle C of the enclosed legislative language have already been passed in H.R. 3030, the "Clean Air Act Amendments of 1990." Second, radon fees referenced in Subtitle C currently exist as part of the Toxic Substances Control Act. Finally, pursuant to an exchange of letters with the Committee on Government Operations, this Committee's recommendations on Medicaid contained in Subtitle B include the provisions of H.R. 5450, the Computer Matching and Privacy Protection Amendments which passed the House on October 1, 1990.

Thank you for your cooperation in these matters.

Sincerely,

JOHN D. DINGELL,
Chairman.

TABLE OF CONTENTS

Subtitle A—Provisions Relating to Medicare Program and Regulation of Medicare Supplemental Insurance Policies

Part 1—Provisions Relating to Part B.

Subpart A—Payment for Physicians' Services (Sec. 4001-4013).

Subpart B—Payment for Other Items and Services (Sec. 4021-4027).

Subpart C—Miscellaneous Provisions (Sec. 4031-4032).

Part 2—Provisions Relating to Parts A and B.

- Subpart A—Peer Review Organization (Sec. 4101–4106).
- Subpart B—Other Provisions (Sec. 4121–4125).
- Part 3—Provisions Relating to Beneficiaries. (Sec. 4201–4202).
- Part 4—Standards for Medicare Supplemental Insurance Policies (Sec. 4301–4309).

Subtitle B—Medicaid Program

- Part 1—Reduction In Spending (Sec. 4401–4403).
- Part 2—Protection of Low-Income Medicare Beneficiaries (Sec. 4411).
- Part 3—Improvements In Child Health (Sec. 4421–4426).
- Part 4—Nursing Home Reform Provisions (Sec. 4431).
- Part 5—Miscellaneous Provisions.
 - Subpart A—Payments (Sec. 4441–4448).
 - Subpart B—Eligibility and Coverage (Sec. 4451–4458).
 - Subpart C—Health Maintenance Organizations (Sec. 4461–4465).
 - Subpart D—Demonstration Projects and Home, and Community-Based Waivers (Sec. 4471–4474).
 - Subpart E—Miscellaneous (Sec. 4481–4485).

Subtitle C—Energy and Miscellaneous User Fees

- Part 1—Energy (Sec. 4501–4502).
- Part 2—Railroad User Fees (Sec. 4511).
- Part 3—Travel and Tourism User Fees (Sec. 4521).
- Part 4—EPA User Fees (Sec. 4531–4532).
- Additional Views.

PURPOSE AND SUMMARY

The purpose of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1990 is to make revisions in Part B of the Medicare program and in the Medicaid program, in accordance with the reconciliation instructions to the Committee on Energy and Commerce contained in the Concurrent Resolution on the Budget—Fiscal Year 1991. The instructions assume \$43.7 billion in savings for the Committee on Energy and Commerce for Fiscal Years 1991–1995 taking into account that other committees which share jurisdiction over Medicare and other programs within the purview of this Committee will contribute to those savings in their reconciliation bills. The instructions further assume new entitlement authority of \$2.0 billion over the period FY 1991 through 1995 for purposes of protecting poor and near-poor Medicare beneficiaries from increased cost-sharing obligations under Part B.

The Committee bill consists of three subtitles: subtitle A, relating to Medicare and Regulation of Medicare Supplemental Insurance Policies; subtitle B, relating to Medicaid; and subtitle C, relating to energy and miscellaneous user fees.

Subtitle A consists of 4 Parts. Part 1 contains changes in payments for physician services under Medicare, changes in payments for other covered items and services covered under Medicare. Part 2 contains changes relating to peer review organizations and other provisions, including an extension of the current Medicare secondary payor provisions for the disabled and ESRD beneficiaries. Part 3 includes changes relating to beneficiaries, including increases in the monthly Part B premium and deductible. Part 4 revises standards for Medicare supplemental insurance policies and provides for Federal enforcement of such standards.

Subtitle B, relating to Medicaid, consists of five parts. Part 1 contains provisions that will achieve savings by reforming the purchase of prescription drugs and requiring State Medicaid programs to pay employer group health insurance premiums on behalf of

Medicaid beneficiaries in cases where this would be cost-effective. Part 2 would extend Medicaid payment for Part B premiums for Medicaid beneficiaries with incomes below 125 percent of the Federal poverty line. This initiative is financed by the \$2.0 billion assumed in the Budget Resolution for this specific purpose. Part 3 contains provisions to improve the health of low-income children, including phased-in mandatory coverage of children up through age 12 in families with incomes at or below 100 percent of the poverty level. These initiatives are financed on a "pay-as-you-go-basis" by the savings achieved in Part 1, as contemplated by the conferees on the Budget Resolution. Part 4 contains amendments relating to the nursing home reform provisions enacted in the Omnibus Budget Reconciliation Act of 1987. Part 5 contains a number of miscellaneous provisions relating to payments, eligibility and coverage, health maintenance organizations, demonstration projects and home and community-based waivers, and other issues.

BACKGROUND AND NEED FOR LEGISLATION

The Concurrent Resolution on the Budget—Fiscal Year 1991 (H.Con.Res. 310, adopted October 9, 1990) provides for unspecified savings in the Medicare program over the period FY 1991 through FY 1995. The Budget Resolution assigns this savings target to both this Committee and the Committee on Ways and Means, without instructions as to how much is to be achieved in Part A, which is not within the jurisdiction of this Committee, and how much is to be achieved in Part B, which is within the jurisdiction of both committees. Therefore, this Committee does not have a specific target for the Medicare savings it must achieve. The net savings from this Committee are consolidated with the net savings from the Committee on Ways and Means to determine whether the target has been met. The Committee is concerned that the increases in Part B premiums and deductibles assumed by the Budget Resolution and contained in this bill will impose a disproportionately heavy financial burden on low-income Medicare beneficiaries. Accordingly, the Committee bill includes a provision to pay the Part B premiums of beneficiaries with income below 125 percent of the Federal poverty level and liquid assets of \$4,000 or less. The Committee also remains concerned that continual reductions in payments to providers of service, without adequate evaluation of the effects of prior reductions, may impact on enrollees in the form of reduced quality of care or barriers to accessibility.

The Budget Resolution also apparently assumes reductions of \$2.38 billion in Medicaid outlays over the period FY 1991 through 1995. The Committee bill would achieve these savings primarily by reforming the purchase of prescription drugs by the States and by requiring the States, where cost-effective, to purchase employer group health coverage on behalf of Medicaid beneficiaries. The savings achieved under the Committee's recommendations would exceed the Budget Resolution's apparent target by approximately several hundred million dollars over the next five years. In an effort to respond to the health care crisis confronting poor children, the Committee is recommending that these savings be applied to initiatives to improve child health. Foremost among these is a

modest, incremental expansion in Medicaid coverage for children through age 12 in families with incomes at or below 100 percent of the Federal poverty level. This will result in the extension of basic health care coverage to an estimated 700,000 children in 1995 when the provision is fully implemented.

HEARINGS

The Subcommittee on Health and the Environment held one day of hearings on Medicare Program Outlay Reductions on June 27, 1990, and heard testimony from 10 witnesses, including the Physician Payment Review Commission, representatives of 6 medical associations, and 3 other organizations. On June 7, 1990, the Subcommittee on Health and the Environment held joint hearings with the Subcommittee on Commerce, Consumer Protection, and Competitiveness on reform of the Medicare Supplemental Insurance Market. Testimony was received from 10 witnesses, including 2 Members of Congress, the General Accounting Office, representatives of the health insurance industry, and 3 other organizations. The Subcommittee on Health and the Environment held field hearings on March 5, 1990, in Atlanta, Georgia, on Medicare Part B Carrier Issues. Testimony was received from 10 witnesses, including 4 Members of Congress, regional offices of the Health Care Financing Administration and HHS Inspector General, and representatives of 4 other groups.

The Subcommittee held two days of hearings on Medicaid Budget Initiatives on September 10, 1990, and September 14, 1990, and heard testimony from 37 witnesses, including nine Members of Congress, the General Accounting Office, HHS Office of the Inspector General, and the Health Care Financing Administration. Illinois, on Medicaid and the Maternal and Child Health Block Grants on March 5, 1990. Testimony was received from 11 witnesses, including the Illinois Department of Public Health, and the Illinois Department of Public Aid, and representatives of various area health care providers.

COMMITTEE CONSIDERATION

On October 11, 1990, the Committee met in an open mark-up session and ordered the Committee Print, as amended, transmitted to the Budget Committee by a voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made to the Committee.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the bill will reduce Medicare program outlays by \$1.7 billion in FY 1991 and \$24.4 billion over the period FY 1991 through 1995, and will reduce Medicaid program outlays by \$337 million over the period FY 1991 through 1995.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 15, 1990.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for the Reconciliation recommendations of the Committee on Energy and Commerce, as ordered transmitted to the House Committee on the Budget, October 15, 1990.

The estimates included in the attached table represent the 1991-1995 effects on the federal budget and on the budget resolution baseline of the Committee's legislative proposals affecting spending. CBO understands that the Committee on the Budget will be responsible for interpreting how savings contained in these legislative proposals measure against the budget resolution reconciliation instructions.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER,
Director.

ENERGY AND COMMERCE: RECONCILIATION PROVISIONS

[By fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	Total 1991-95
SUBTITLE A—PROVISIONS RELATING TO THE MEDICARE PROGRAM						
Part 1—Provisions Relating to Part B						
4001 Payments for Overvalued Procedures.....	-115	-190	-210	-235	-260	-1010
4002 Payments for radiology services.....	-87	-153	-176	-194	-229	-837
4003 Payments for anesthesia services.....	-35	-50	-55	-60	-65	-265
4004 Payments for pathology services.....	-10	-10	-15	-15	-15	-65
4005 Payments for certain other physician services.....	-95	-155	-175	-190	-215	-830
4006 Update for physicians services.....	-195	-390	-475	-525	-590	-2,175
4007 Charges of new physicians and practitioners.....	-55	-105	-125	-140	-155	-580
4008 Payment for technical components of diagnostic tests....	-20	-35	-35	-40	-45	-175
4009 Reciprocal billing arrangements for physicians.....	0	0	0	0	0	0
4010 Aggregation rule for claims for similar physicians' services.....	0	0	0	0	0	0
4011 Practicing physicians advisory council ¹	0	0	0	0	0	0
4012 Release of medical review screens.....	0	0	0	0	0	0
4013 Technical corrections relating to physician payment.....	0	0	0	0	0	0
4021 Payments for hospital outpatient services:						
a. Outpatient capital.....	-65	-90	-85	-90	-80	-410
b. Outpatient services.....	-115	-150	-180	-210	-245	-900

ENERGY AND COMMERCE: RECONCILIATION PROVISIONS—Continued

[By fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	Total 1991-95
4022 Payments for durable medical equipment.....	-170	-305	-380	-445	-490	-1,790
4023 Payment for clinical laboratory services.....	-95	-155	-175	-200	-225	-850
4024 Coverage of nurse practitioner in rural areas.....	3	4	5	5	6	23
4025 Clarifying coverage of eyeglasses following cataract surgery.....	-30	-45	-50	-50	-55	-230
4026 Coverage of injectible drugs for cataract surgery.....	1	1	0	0	0	2
4027 Conditions of cataract surgery alternatives demonstration.....	0	0	0	0	0	0
4031 Medicare carrier notice to State medical boards.....	0	0	0	0	0	0
4032 Technical and miscellaneous corrections to part B.....	0	0	0	0	0	0
Subtotal.....	-1,083	-1,828	-2,129	-2,389	-2,563	-10,092
Part 2—Provisions Relating to Parts A & B						
4101 PRO coordination with carriers.....	0	0	0	0	0	0
4102 Confidentiality of peer review deliberations.....	0	0	0	0	0	0
4103 Role of peer review in hospital transfers.....	0	0	0	0	0	0
4104 Peer review notice.....	0	0	0	0	0	0
4105 Notice to State medical boards of adverse actions.....	0	0	0	0	0	0
4106 Carrier notice to State medical boards.....	0	0	0	0	0	0
4121 Extension of medicare secondary payor provisions:						
a. ESRD to 18 months.....	-50	-55	-60	-65	-65	-295
b. Extension of disabled secondary payer provisions.....	0	-570	-780	-800	-830	-2,980
4122 Provisions relating to HMO's.....	(2)	(2)	(2)	(2)	(2)	(2)
4123 Demonstration project for staff-assisted home dialysis.....	1	1	0	0	0	2
4124 Extension of reporting deadline for Alzheimer's disease demonstration project.....	0	0	0	0	0	0
4125 Miscellaneous technical corrections.....	0	0	0	0	0	0
Subtotal.....	-49	-624	-840	-865	-895	-3,273
Part 3—Provisions Relating to Beneficiaries						
4201 Part B premium ^a	-275	-370	-1,320	-2,590	-3,965	-8,520
4202 Change in part B deductible.....	-350	-550	-560	-570	-580	-2,610
Subtotal.....	-625	-920	-1,880	-3,160	-4,545	-11,130
Part 4—Standards for Medicare Supplemental Insurance Policies						
4301 Simplification of Medicare supplemental policies ¹	0	0	0	0	0	0
4302 Requiring approval of State for sale in the State.....	0	0	0	0	0	0
4303 Preventing duplication.....	0	0	0	0	0	0
4304 Loss ratios ¹	0	0	0	0	0	0
4305 Limitation on certain sales commissions.....	0	0	0	0	0	0
4306 Clarification of treatment of plans offered by health maintenance organizations.....	0	0	0	0	0	0
4307 Prohibition of certain discriminatory practices.....	0	0	0	0	0	0
4308 Health insurance advisory service for medicare beneficiaries.....	0	0	0	0	0	0
4309 Additional enforcement through Public Health Service Act.....	0	0	0	0	0	0
Subtotal.....	0	0	0	0	0	0
Medicare subtotal.....	-1,737	-3,372	-4,849	-6,414	-8,103	-24,495
Subtitle B—Medicaid Program						
Part 1—Reductions in Spending						
4401 Reimbursement for prescribed drugs.....	-100	-250	-445	-570	-740	-2,105

ENERGY AND COMMERCE: RECONCILIATION PROVISIONS—Continued

[By fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	Total 1991-95
4402 Requiring Medicaid payment of premiums and cost-sharing for enrollment under group health plan where cost effective.....	-85	-160	-205	-250	-305	-1,005
4403 Computer matching and privacy protection amendments.....	0	-15	-35	-40	-45	-135
Part 2—Protection of Low-Income Medicare Beneficiaries						
4411 Medicaid payment for premiums for Medicare beneficiaries with incomes below 125 percent of poverty.....	200	285	360	470	595	1,910
Part 3—Improvements in Child Health						
4421 Phased-in mandatory coverage of children up to 100 percent of poverty.....	10	55	105	160	230	560
4422 Mandatory continuation of benefits for pregnant women through post-partum and certain infants throughout first year of life.....	15	30	35	35	40	155
4423 Mandatory use of Outreach locations other than welfare offices.....	9	50	55	55	60	229
4424 Presumptive eligibility.....	1	1	2	2	2	8
4425 Role in paternity determinations.....	(²)	(²)	(²)	(²)	(²)	(²)
4426 Report and transition on errors in eligibility determinations.....	(²)	(²)	0	0	0	0
Part 4—Nursing home reform provisions						
4431 Medicaid nursing home reform.....	-1	-2	-2	-2	-3	-10
Part 5—Miscellaneous provisions						
4441 State Medicaid matching payments through voluntary contributions and State taxes.....	0	0	0	0	0	0
4442 Disproportionate share hospitals.....	0	0	0	0	0	0
4443 Alternate State payment adjustments to disproportionate share hospitals.....	0	0	0	0	0	0
4444 Minimum payment adjustment for certain disproportionate share hospitals in Illinois.....	10	10	10	0	0	30
4445 Federally qualified health centers.....	3	4	4	4	4	19
4446 Hospice payments.....	0	0	0	0	0	0
4447 Limitations on disallowance of certain inpatient psychiatric hospital services.....	0	0	0	0	0	0
4448 Treatment of interest on Indiana disallowance.....	0	0	0	0	0	0
4451 Optional payment of premiums for "COBRA" continuation coverage where cost effective.....	0	0	0	0	0	0
4452 Provisions relating to spousal impoverishment.....	0	0	0	0	0	0
4453 Disregarding German reparation payments from post-eligibility treatment of income under the Medicaid Program.....	(²)	1	1	1	1	4
4454 Amendments relating to Medicaid transition provision.....	0	0	0	0	0	0
4455 Clarifying effect of hospice election.....	0	0	0	0	0	0
4456 Clarification of application of 133 percent income limit to medically needy.....	0	0	0	0	0	0
4457 Codification of coverage of rehabilitation services.....	0	0	0	0	0	0
4458 Personal care services in Minnesota.....	1	1	1	1	1	5
4461 Requirements for health maintenance organizations.....	0	0	0	0	0	0
4462 Health maintenance organization special rules.....	0	0	0	0	0	0
4463 Extension and expansion of Minnesota prepaid demonstration.....	0	0	0	0	0	0
4464 Treatment of Dayton area health plan.....	-2	-2	-2	-2	-2	-10
4465 Treatment of certain county-operated health insuring organizations.....	0	0	0	0	0	0
4471 Waiver authority for demonstrations to protect assets through private long-term care insurance.....	0	0	0	0	0	0
4472 Timely payment under waivers of freedom of choice of hospital services.....	0	0	0	0	0	0

ENERGY AND COMMERCE: RECONCILIATION PROVISIONS—Continued

[By fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	Total 1991-95
4473 Home and community-based services waivers:						
(1) Clarify definition of room and board.....	0	0	0	0	0	0
(2) Treatment of persons with mental retardation or a related condition in a decertified facility.....	0	0	0	0	0	0
(3) Scope of respite care.....	0	0	0	0	0	0
(4) Permitting adjustment in estimates to take into account preadmission screening requirement.....	0	0	0	0	0	0
4474 Provisions relating to frail elderly demonstration project waivers:						
(a) Expansion of waivers.....	(²)	(²)	(²)	(²)	(²)	(²)
(b) Application of special improvement rules.....	(²)	(²)	(²)	(²)	(²)	(²)
4481 Right to self-determination with respect to health care ..	(²)	1	1	1	1	4
4482 Provisions relating to quality of physician services.....	(²)	1	1	1	1	4
4483 Clarification of authority of inspector general.....	0	0	0	0	0	0
4484 Notice to State medical boards when adverse actions taken.....	0	0	0	0	0	0
4485 Miscellaneous provisions.....	(²)	(²)	(²)	0	0	(²)
Medicaid Subtotal.....	61	10	-114	-134	-160	-337
SUBTITLE C—OTHER PROVISIONS						
4502 NRC fees (offsetting receipts).....	-287	-298	-310	-323	-336	-1,554
4511 Railroad safety user fees (offsetting receipts).....	-20	-35	-36	-38	-40	-169
4521 U.S. travel and tourism user fees (offsetting receipts)....	-10	-19	-18	-20	-18	-85
4531 EPA user fees (offsetting receipts).....	-4	-5	-5	-5	-5	-24
Other total direct spending effects.....	-321	-357	-369	-386	-399	-1,832
Direct spending total.....	-2,017	-3,719	-5,332	-6,934	-8,662	-26,664
State and local effects.....	-85	-180	-275	-295	-325	-1,160

¹ No direct spending would result from this provision, but a small amount (less than \$500,000) would be required from funds subject to Appropriation Committee action.

² Cost or saving estimated at less than \$500,000.

³ Part B monthly premium amounts: 1991, \$30.90; 1992, \$32.20; 1993, \$37.00; 1994, \$41.70; 1995, \$44.70.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee states that the reported bill will reduce inflation by reducing Medicare and Medicaid program outlays by over \$27 billion over the next 5 years.

SECTION-BY-SECTION ANALYSIS

PART 1—PROVISIONS RELATING TO PART B

*Subpart A—Payment for Physicians' Services**Section 4001—Certain overvalued procedures*

The Omnibus Budget Reconciliation Act of 1989 provided for reductions in the prevailing charges for a list of 244 procedures identified as overvalued in relation to the amounts estimated for such procedures under the Medicare Fee Schedule beginning in 1992. The Physician Payment Review Commission (PhysPRC) recommended these specific procedures for reductions because the national average prevailing charges for these procedures exceeded the estimated fee schedule amounts by at least 10 percent.

Beginning on April 1, 1990, payments for these services were reduced by one-third of the amount by which they exceeded the estimated fee schedule amount, but not in excess of 15 percent. Estimated fee schedule amounts for these services in each locality were adjusted to reflect geographic variations in the cost of practice.

The Committee bill instructs the Secretary to reduce the prevailing charge in each locality for the procedures identified as overvalued by one-third of the amount by which it exceeds the locally-adjusted estimated fee schedule amount, but in no case shall that reduction exceed 15 percent. The effect of this provision is an additional one-third reduction in the remaining difference between the prevailing charge in 1990 and the estimated fee schedule amount.

The adjustment for geographic variations in prevailing charges under this provision would recognize both relative differences in practice costs and the value of physicians' work. In the case of the index reflecting geographical differences in the value of physicians' work, only one quarter of the index value would be applied.

Section 4002—Radiology services

Since January 1, 1989, payments for radiology services have been made on the basis of a fee schedule incorporating relative values established by the Secretary. The fee schedule amounts in each locality are not subject to adjustment by geographical adjustment factors. However, in 1989 and in 1990 the conversion factors established in each locality were reduced by 3 percent and 4 percent, respectively.

The Committee bill would make several changes in the payment methodology for radiology services. First, in 1991, payments for radiology services (other than for portable X-ray services) would be determined in the following manner. The Secretary would be directed to calculate the national weighted average of the locality conversion factors applied as of April 1, 1990 (standardized for geographical differences in the cost of practice and physicians' work effort). This national average would be reduced by 11 percent, and multiplied by a blended geographical adjustment value for each locality. The amount determined for each locality would be the conversion factor for 1991, except that in no case would a conversion factor be less than 92 percent of the conversion factor established as of April 1, 1990.

The blended geographical adjustment value applied to the national weighted average conversion factor for 1991 would be the sum of (a) $\frac{3}{4}$ of the index value for the locality that reflects the ratio of the 1990 locality conversion factor to the national weighted average conversion factor; and (b) $\frac{1}{4}$ of the index value for the locality that would apply under the Medicare fee schedule. In 1992 and 1993, this blend would become 50/50 and 25/75, respectively, for purposes of the radiology fee schedule. In 1994, the full geographic adjustment factor determined under the Medicare fee schedule would be applied in determining the locality conversion factors for radiology services.

The Committee recognizes that locality conversion factors currently applied under the radiology fee schedule vary considerably. Thus, the use of a blended geographical adjustment factor provides a more gradual transition to a fee schedule that will narrow the

range of variation among localities, and is consistent with the transition provided for under the Medicare fee schedule.

The Committee bill includes a prohibition against the use of the Medicare comparability fee rule with respect to radiology services under the fee schedule, effective January 1, 1992.

The Committee bill would clarify that payments under the radiology fee schedule would be differentiated by carrier localities as is currently the case for other physician payments under Medicare. This provision would be effective as if included in the Omnibus Budget Reconciliation Act of 1987.

The Omnibus Budget Reconciliation Act of 1989 provided a special rule for the determination of payments for nuclear medicine services provided by physicians for whom such services represent at least 80 percent of total charges billed under Medicare. The Committee is advised that new information concerning the appropriate relative values for nuclear medicine services will be available in advance of the implementation of the Medicare fee schedule in 1992. Accordingly, the Committee bill would continue the exemption from the radiology fee schedule in current law at the blended amount specified for 1990.

Finally, the Committee bill would extend the provision in current law providing for the continuation of the split billing rule for cardiovascular and interventional radiologists through 1991.

Section 4003—Anesthesia services

Anesthesia services provided to Medicare beneficiaries are paid on the basis of a fee schedule based in part on a uniform relative value guide. As in the case of the fee schedule for radiology services, there is currently no adjustment in the locality anesthesia conversion factor to reflect geographic variations in either the costs of practice or the physicians' work effort.

The Committee bill would establish a revised method for determination of the anesthesia conversion factors in 1991. The locality conversion factor would be determined by calculating the national weighted average conversion factor, reducing it by 7 percent, and applying the appropriate blended geographical adjustment value for each locality. The resulting adjusted locality conversion factor would in no case be more than 15 percent below the locality conversion factor applied as of April 1, 1990.

As in the case of the geographic adjustment applied to the radiology fee schedule, the weighted national average anesthesia conversion factor for 1991 would be adjusted by a blended index value consisting of one half the ratio of the 1990 locality conversion factor to the national weighted average, and one-half the geographic adjustment factor for the locality determined under the Medicare fee schedule.

In addition, the Committee bill would also extend through 1995 current law provisions limiting payments for medical direction of two or more certified registered nurse anesthetists providing services concurrently.

Section 4004—Physician pathology services

Current law authorizes the Secretary to implement a national fee schedule for physician pathology services incorporating the geo-

graphic adjustment methodology applied in the Medicare fee schedule, effective January 1, 1991.

The Committee has determined that the separate fee schedule for physician pathology services is no longer needed and should not be implemented. Instead, it is the Committee's view that these services, which are under review by the Health Care Financial Administration and the PhysPRC, should be incorporated in the resource-based relative value scale and paid for under the Medicare fee schedule beginning in 1992.

Therefore, the Committee bill deletes the provision requiring implementation of a national fee schedule. The bill further directs the Secretary to reduce the prevailing charges in each locality for physician pathology services determined for 1991 by 7 percent.

Section 4005—Prevailing charges for miscellaneous physician procedures

There are a number of physician services which have not yet been evaluated for purposes of establishing resource-based relative values in preparation for implementation of the Medicare fee schedule in 1992. For the most part these services include certain surgical and diagnostic procedures. Analyses by the PhysPRC of phase one of the Harvard resource-based relative value study showed that 94 percent of physician services other than evaluation and management services are overvalued to some extent. The Committee recommended a uniform percentage reduction to certain unsurveyed services.

The Committee bill would direct the Secretary to reduce selected prevailing charges in each locality by 2 percent, or in the case of global surgical fees (not included in the list of 244 overvalued services) by 4 percent. Excluded from these reductions are radiology, anesthesiology and physician pathology services, primary care services, and certain services that are estimated to be undervalued.

The Committee believes these reductions are consistent with the effect of the Medicare fee schedule, and represent a reasonable transition to the payment amounts that will be established for these services in 1992.

Section 4006—Update for physicians' services

Current law provides for annual increases in Medicare payments for physician and other services to reflect the effects of inflation on the provision of services and supplies. Physician services are updated by the estimated Medicare Economic Index (MEI) for the calendar year. The Congressional Budget Office estimates that the MEI for 1991 would allow a 3.6 percent increase in prevailing charges of physicians' services.

The Committee bill would permit the full MEI update for 1991 to be applied to all primary care services. However, in order to achieve savings required by the budget resolution for fiscal year 1991, the schedule MEI update for other physician services would be eliminated. The Committee recognizes that this change in current law is not consistent with physician payment policies adopted in recent legislation, but the magnitude of savings required under the budget resolution leaves the Committee with few alternatives. Increases for primary care services would be consistent with the es-

timated effects of the Medicare fee schedule that will be implemented in 1992.

The Committee also recognizes that prevailing charges for primary care services in certain areas—especially rural areas—are relatively low in comparison with national average prevailing charges for these services. Current law establishes a floor for prevailing charges for primary care services in any locality that is equal to 50 percent of the national average prevailing charge for the service.

Since primary care services are expected to increase in value under the Medicare fee schedule, and since the current Maximum Allowable Actual Charge (MAAC) limits for physicians' services will be replaced by new balance billing limits on January 1, 1991, the Committee is concerned that payments for these services could be unreasonably constrained in historically low charging localities, and could result in limitations on the access of beneficiaries. Moreover, the Committee wishes to avoid the anomalous effect of lowering payments for primary care services in 1991 which would be raised in the following year under the fee schedule.

Therefore, the Committee bill would increase the floor for primary care services from 50 percent of the national average prevailing charge to 75 percent. Prevailing charges for these services would be increased in some localities by as much as 25 percent making application of the new balance billing limits to these services less stringent. The bill would also require the Secretary to disregard this increase in the primary care floor for purposes of determining payments under the fee schedule in 1992, except that in no case would payments under the fee schedule in 1992 be less than the prevailing charge determined for primary care services in 1991.

Section 4007—New physicians and other new health care practitioners

Current law requires that customary charges of new physicians be established no higher than 80 percent of the locality prevailing charge in the first year of practice and no higher than 85 percent of the prevailing amount in the second year. This limitation on initial customary charges does not apply to primary care services or services provided in a rural health manpower shortage area.

The Committee bill would revise this policy in two ways. First, the limitation on initial customary charge levels would be extended to the third and fourth years of practice at no higher than 90 percent and 95 percent of prevailing charges or fee schedule amounts, respectively. Second, these limitations would also apply in the case of customary charges or fee schedule amounts applicable to other health care practitioners including physician assistants, certified nurse-midwives, psychologists, nurse practitioners, clinical social workers, physical therapists, occupational therapists, respiratory therapists, and certified registered nurse anesthetists.

Section 4008—Technical components of diagnostic tests

Medicare uses the customary and prevailing charge method to pay for the technical components for diagnostic tests (except for clinical laboratory and radiology services) provided incident to physician professional services. Diagnostic tests involving separate pay-

ments for a technical component include pacemaker monitoring, cardiac stress tests, echocardiography, and electrocardiograms. Currently, there is significant geographic variation in Medicare prevailing charges for the technical component of such tests.

The Committee bill would apply a cap at 100 percent of the national median of prevailing charges (or fee schedule amounts) for the technical components of diagnostic tests (other than clinical laboratory and radiology tests), effective January 1, 1991.

Section 4009—Recognizing reciprocal billing arrangements

Under current law, payment of claims for covered services under Part B of Medicare must be made to a beneficiary, or under an assignment agreement, to the physician, practitioner or supplier who provides the service. Exceptions to this payment rule permit employers of practitioners and other entities to receive payments on behalf of such practitioners.

The Committee understands that historically physicians have entered into informal arrangements with other physicians to arrange for the provision of necessary services to their patients when they are not available to personally perform such services. Thus, a physician's patients who may be hospitalized or require immediate medical attention during their absence may be seen by another physician who has agreed to provide such coverage. Generally, these arrangements provide that claims for any visit services, or services incident to such visits, provided by a covering physician will be submitted by the physician who is not available and payment will be made to such physician.

The Committee bill would clarify current law by setting forth conditions for recognition of reciprocal billing arrangements. Payment would be authorized to a physician for visit services or services incident to such visits (including emergency visit services), provided to a Medicare beneficiary by a second physician under a reciprocal billing arrangement, if such arrangement has been made and the following conditions are met. First, the primary physician is unavailable to render care; second, patient has arranged for or seeks physician services from the primary physician; third, the claim for payment includes the unique physician identifier code of the second physician; and fourth, such covered services are not provided over a continuous period in excess of 30 days.

The Committee understands that these reciprocal billing arrangements will be permitted to accommodate long-standing physician practices with respect to coverage for patient services during periods of professional education or vacation. However, the Committee believes that such arrangements should be limited as provided here, and that, apart from these occasional circumstances and other exceptions in current law, payments for physicians' services should be made only to the physician who personally provides a covered service.

Section 4010—Aggregation rule for claims for similar physicians' services

Under current law, individuals entitled to benefits under Medicare may appeal an adverse determination by the Secretary with respect to such entitlement or the amount of benefits, and be

granted a hearing by the Secretary and the right to judicial review under certain circumstances. Individuals may designate the provider of the services in dispute as their representative in such proceeding.

Under Part B of Medicare, with respect to a hearing by the Secretary, the amount in controversy must be at least \$500; and, with respect to judicial review, the amount in controversy must be at least \$1,000. In determining the amount in controversy, individuals may aggregate denied claims that involve the delivery of similar or related services, or claims that involve common issues of law and fact for two or more individuals.

The Committee bill would revise these aggregation rules by specifying that claims subject to these provisions may be aggregated so long as they are for services furnished during the same 12 month period. In addition, the Committee bill would permit the aggregation of claims involving common issues of law and fact for two or more individuals for physicians' services furnished in the same fee schedule area for two or more physicians. In the case of an appeal of multiple claims involving two or more physicians within the same fee schedule area, the amount in controversy must be at least \$1000 to qualify for a hearing by the Secretary, and \$2500 for judicial review.

Section 4011—Practicing physicians advisory council

The Secretary of Health and Human Services currently receives advice from the Prospective Payment Advisory Commission with respect to payment policy for institutional services covered under Medicare, and from the Physician Payment Review Commission with respect to payments for practitioner services. In addition, the Secretary from time to time consults with other physician advisors including those employed in the Department, involved in research, medical education, and representatives of medical organizations, including specialty organizations, on matters concerning the application of coverage and payment policies effecting the Medicare program.

The Committee recognizes that changes in Medicare policies enacted by Congress and imposed by regulation have resulted in a significant expansion in the administrative complexity of the program. As a result, Medicare contractors, practitioners, and patients have been required to adapt to a series of fundamental program changes over the past few years. While advice is routinely solicited from representatives of Medicare contractors, there is currently no formal advisory group including representatives of practitioners.

The Committee bill would establish a formal practicing physician advisory council, composed of 15 representatives of physicians and practitioners in active practice, to provide advice to the Secretary concerning proposed regulations and carrier manual instructions issued under Part B of the Medicare program. The Council would meet once in each calendar quarter, and would, to the extent feasible, comment on proposed changes in regulations or manual instructions prior to their publication.

Section 4012—Release of medical review screens and associated screening parameters

Under current law, Medicare carriers are required to make determinations with respect to claims for covered services that such services are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Carriers apply screens incorporating specific parameters to identify those claims that should be subjected to medical review. Medical review, performed by appropriate health care professionals, employs criteria developed by the carriers in consultation with local practitioners. These screens and parameters are not designed to represent and do not constitute clinical practice guidelines; rather they are statistically based tools used for the purpose of identifying a subset of claims where additional medical review is indicated. Claims failing such screens are subjected to medical review by carrier physicians prior to any final payment determination.

The Committee has been informed that these medical review screens, the associated screening parameters, and the criteria upon which denial of payment may be made were, prior to 1987, available to the public. Related screens and screening parameters developed by local carriers were available to the public at the option of the carrier. The Committee notes that the Health Care Financing Administration has announced plans to release these items in selected carrier areas and to monitor the impact on the delivery of services prior to and subsequent to their release.

The Committee bill would require the Secretary to provide for the public release of medical review screens, the associated screening parameters, and review criteria by each Medicare carrier, effective on or after January 1, 1991. The Committee anticipates that the Health Care Financing Administration will monitor the impact of this release on the provision of services covered under Part B, and advise the appropriate Committees of Congress of its findings and recommendations.

It has also come to the Committee's attention that some carriers have imposed charges on requests by practitioners for certain information required for timely and complete submission of Part B claims. The Committee believes that carriers should make available to physicians and other practitioners necessary billing information including the identifier number of a referring physician, prevailing charge limits or fee schedule amounts, and coding definitions or protocols on a timely basis without charge.

Subpart B—Payment for Other Items and Services

Section 4021—Hospital outpatient services

Payments to hospitals for outpatient services are determined on the basis of actual charges, reasonable costs, a blended rate of reasonable costs and fee schedule amounts, or fee schedules. Capital costs of hospitals allocated to outpatient departments are currently paid at 85 percent of allowable costs. Outpatient capital costs of sole community hospitals are exempt from the 15 percent reduction in current law. The reductions in capital costs payments for hospi-

tals expired at the end of fiscal year 1990. Payments for the facility costs for ambulatory surgery centers are paid on the basis of prospectively determined rates.

The Committee notes that the Health Care Financing Administration failed to provide any update to ambulatory surgery center payment rates between 1982 and 1987. Since that date only one additional update has been applied despite the requirements for annual adjustments in Section 1833(i)(2)(A) of the Social Security Act. The Committee is disappointed that the Secretary has not provided the required updates in a timely manner.

The Committee bill would make three changes in current law with respect to payments for hospital outpatient services and services provided by ambulatory surgery centers.

(a) Continuation of Reduction in Payments for Capital-Related Costs.—Payments for the outpatient capital costs of hospitals would be reduced by the following percentages: 10 percent for portions of cost reporting years occurring on or after October 1, 1990 and before October 1, 1991; 10 percent for portions of cost reporting years occurring on or after October 1, 1991 and before October 1, 1992; 7.5 percent for portions of cost reporting years occurring on or after October 1, 1992 and before October 1, 1993; 7.5 percent for portions of cost reporting years occurring on or before October 1, 1993 and before October 1, 1994; and 5 percent for portions of cost reporting years occurring on or before October 1, 1994 and before October 1, 1995. The exemption for sole community hospitals would be continued.

(b) Reduction in Amount of Payments Otherwise Determined.—For outpatient hospital services (other than clinical laboratory services, outpatient radiology services, certain other diagnostic services, and renal dialysis services), payment would be made on the basis of the lesser of reasonable costs or charges reduced by 5 percent for portions of cost reporting years occurring on or after October 1, 1990 and before October 1, 1995. For purposes of determining the payment limitation amount for hospital ambulatory surgery services, reductions in both the cost portion and the standard overhead amount of the blended rate would be made to result in an aggregate reduction of 5 percent. Hospitals receiving a disproportionate share payment would be exempt from reductions applied under this part.

(c) Payments for Ambulatory Surgical Procedures.—The Committee bill also would make certain changes in payments for facility services furnished by ambulatory surgical centers. The payment allowance for an intraocular lens for post-cataract surgical patients would be frozen at \$200 until January 1, 1993. The Secretary would be directed to determine future rates for services furnished by ambulatory surgical centers on the basis of a survey of audited cost data from a representative sample of centers. Rates based on such data would be applied on or after July 1, 1992 and every 5 years thereafter. Such rates would be updated each year by the Secretary or, if the Secretary fails to provide an update, by the percentage increase in the Consumer Price Index for all urban consumers for the period ending with June of the preceding year. The Secretary would also be required to update the procedures authorized for pay-

ment in ambulatory surgery centers in consultation with representatives of interested trade and professional organizations.

Section 4022—Provisions relating to payments for durable medical equipment

Current Law—(a) The Omnibus Budget Reconciliation Act of 1989 provided for an across-the-board reduction in the fee schedule amounts recognized for seat-lift chairs and transcutaneous electrical nerve stimulators (TENS) of 15 percent.

(b) Current law provides for a transition to regionally-based fee schedules for certain categories of durable medical equipment (DME) effective in 1993. Items subject to these regional fee schedules include: orthotic and prosthetic devices; rental-cap items; and oxygen and oxygen equipment. Regional fee schedule amounts are calculated on the basis of a weighted average of local amounts and regional averages. In 1989 and 1990, payments are based solely on local fee schedule amounts; in 1991 and 1992, payments are based on a blend of regional and local fee schedule amounts; and in 1993 and subsequent years, payments are based solely on regional fee schedule amounts. Payments in 1991 and 1992 would be bound by a ceiling equal to a fixed percentage of the national average of all carrier service fees and a floor equal to a fixed percentage of the same national average fee schedule amount.

In determining the purchase price of a covered item of durable medical equipment, the Secretary is authorized in 1991 to make adjustments in each locality based on applying inherent reasonableness rules.

(c) Certain items of durable medical equipment are paid for under a monthly rental agreement that may continue for up to 15 months. The amount of the monthly rental fee is equal to 10 percent of the purchase price of the item as determined by average locality submitted charges during a base period updated by the CPI-U. After the expiration of the rental period, payments equal to one month's rental are authorized every six months for maintenance.

The Omnibus Budget Reconciliation Act of 1989 re-classified power-driven wheelchairs from rental cap items to the frequently purchased category with discretion for the Secretary to treat such wheelchairs as customized equipment and authorized for lump-sum purchase under guidelines to be established by the Secretary.

(d) Enteral and parenteral equipment and supplies are paid for on a reasonable charge basis in each locality, updated annually by the CPI-U.

(e) There are currently no requirements for prior approval of items and supplies covered under the DME benefit.

(f) As a condition of coverage for items of DME furnished to patients, a physician must prescribe the item and must complete a certificate of medical necessity to accompany any claim for payment.

(g) Suppliers of DME may elect to be participating suppliers with respect to all of their Medicare claims, or they may determine whether to submit claims under assignment on a case-by-case basis. Currently, there are no limits on charges billed to patients when a DME claim is not submitted under assignment.

(h) Under current law, payment for oxygen and oxygen equipment is based on local average monthly reasonable charges, reduced by 5 percent in 1989 and 1990, and updated by the CPI-U. In 1991 and 1992, the local payment amount is a blend of the local and regional average monthly amounts, limited by a designated range based on the national average monthly amounts. Patients certified for coverage of home oxygen therapy are not required to be re-tested to determine continued eligibility.

(i) Orthotic and prosthetic devices are, under current law, included in one of the six payment categories for DME. Locality fee schedule amounts are updated annually by the CPI-U, and are scheduled to be determined fully on a regional basis in 1993.

The Committee bill would make a number of changes in the payment methodology for covered DME items and supplies. In general, the Committee believes that the current variations in payment amounts for covered items and supplies is excessive, that the basis for determining purchase prices for certain items recognizes unreasonably high submitted charges, and that certain reforms are necessary to assure prudent purchasing practices and to protect the beneficiary from unreasonable financial burdens.

(a) *Additional 15-percent reduction in payments for seat-lift chairs and TENS.*—The Committee bill would further reduce the recognized payment amounts for seat-lift chairs and TENS by 15 percent, effective January 1, 1991.

(b) *Development and application of national limits on fees.*—The Committee bill would make changes in the method for determining amounts in four categories of DME: (1) inexpensive and routinely purchased DME; (2) items requiring frequent and substantial servicing; (3) miscellaneous items; and (4) oxygen and oxygen equipment. In general, these provisions would delete the current law requirements related to the establishment of regional fee schedules for items in these categories. In lieu of regional fee schedules, national fee schedules would be established for 1993 with a two year transition period. During the transition to a national fee schedule amount, the local fee schedule amount would be a blend of the local fee and the national weighted average of local fees. In no case would the local, blended fee schedule amount exceed the national weighted average amount or be less than 85 percent of the national average amount. Fee schedules would be updated annually by the CPI-U for the 12 month period ending with June of the previous year.

The provision in current law delaying application of inherent reasonableness rules until January 1, 1991, would be extended for one year.

(c) *Treatment of "rental cap" items.*—The Committee bill would continue the 15 month rental period for certain items of DME, but would revise the method for determining the purchase price of such items and the amount of the monthly rental. Monthly rental payments would be equal to 10 percent of the allowable purchase price of the item for the first three months and 7.5 percent of the allowable purchase price for the remaining twelve months of the rental agreement. At the ninth month of a rental agreement, a patient may elect to purchase the item in which case rental payments would cease after thirteen months. Maintenance payments would

be permitted on the same basis as allowed after the expiration of a rental agreement. In addition, patients would be permitted to commence a new rental period after continuous use of an item has exceeded a period of useful life established by the Secretary, or the item is lost or irreparably damaged under conditions established by the Secretary in regulations.

Non-customized power-driven wheelchairs would be re-classified into the rental cap category, however, the Secretary's option for treating such wheelchairs as customized equipment would be retained.

(d) Freeze in reasonable charges for parenteral and enteral nutrients, supplies, and equipment during 1991.—The Committee bill would freeze payments for enteral and parenteral nutrients, supplies, and equipment in 1991 at charge levels allowed during 1990.

(e) Requiring prior approval for potentially overused items.—The Committee bill would direct the Secretary to develop and periodically update a list of DME items that, on the basis of prior experience, are frequently over utilized. At a minimum, such list would include seat-lift chairs, TENS, and motorized scooters. Items included on such a list would require prior approval as a condition of payment.

(f) Prohibition against distribution of medical necessity forms by suppliers.—The Committee bill would prohibit suppliers of covered DME items from distributing to physicians or beneficiaries for a commercial purpose a partially or fully completed certificate of medical necessity or any other documents that may be required by the Secretary in order to establish that the item is reasonable and necessary for a patient. Violations of this prohibition would be punishable by civil monetary fines of up to \$1,000.

(g) Limiting charges of nonparticipating suppliers.—The Committee bill would extend to suppliers of DME balance billing limits with respect to claims not submitted under assignment. The supplier may not charge the beneficiary an amount that exceeds the limiting charge for that year. The 1991, 1992, and 1993 limit on balance billing is equal to 125, 120, and 115 percent, respectively, of the Medicare allowable charge or fee schedule amount in each such year. Violations of these balance billing limits are the same as those provided for physicians who exceed their billing limits.

(h) Recertification for certain patients receiving home oxygen therapy services.—The Committee bill would provide for the recertification of certain patients receiving home oxygen therapy prior to the expiration of the initial 60-day period of coverage. Patients whose initial need for oxygen therapy is at or near current coverage limits, as determined by blood gas tests, would be required to be re-tested within the final 15 days of the initial 60 day coverage period to determine the need for continued coverage, effective January 1, 1991. The Committee notes a recent study by the General Accounting Office found a significant number of these patients were determined to no longer need such therapy upon re-testing.

(i) Study of separate fee schedules for certain suppliers of prosthetic devices, orthotics, and prosthetics.—The Committee bill includes a provision directing the Secretary to conduct a study of the feasibility and desirability of establishing a separate fee schedule for prosthetic and orthotic practitioners. The Committee understands

that, in establishing the fee schedule for these services required under the Omnibus Budget Reconciliation Act of 1987, charges of all suppliers of these items were commingled. Since some suppliers of these items are also allowed to bill separate fees for professional services, submitted charges for the cost of the prosthetic or orthotic items do not include a professional service component. Prosthetic and orthotic practitioners generally bill charges incorporating both professional fees and acquisition charges for supplied items. The Committee has been informed that current fee schedule amounts for these items are significantly below the historic reasonable charges recognized for these practitioners prior to the fee schedule. The Secretary is directed to report his recommendations to Congress within one year of the date of enactment of this provision.

Section 4023—Clinical diagnostic laboratory tests

Clinical laboratory services are paid for under current law on the basis of fee schedules in each carrier locality. Currently, these fee schedule amounts are subject to a national limitation which is established at 93 percent of the national median of all fee schedule amounts on a carrier-wide basis. Payments under the fee schedules are equal to 100 percent of the recognized amount without any patient co-insurance. Annual updates to the fee schedules equal to the percentage increase in the CPI-U are provided. Generally, clinical laboratories are required to bill Medicare carriers directly for services provided to beneficiaries, including laboratories in physicians' offices.

(a) *Reduction in national cap fee schedules.*—The Committee bill would provide for the full CPI-U update to clinical laboratory fee schedules on January 1, 1991. The national limitation on locality fee schedules would be established at 85 percent of the median of all carrier fee schedules, effective January 1, 1991.

(b) *Clarification of mandatory assignment for tests performed by a physician office laboratory.*—The Committee bill would clarify current statutory language to require that all clinical laboratory tests performed in a physician's office for the benefit of Medicare patients must be billed on an assignment basis. This clarification would be effective as if included in the Omnibus Budget Reconciliation Act of 1989.

(c) *Technical corrections.*—This section of the Committee bill would make certain technical corrections to the "shell" laboratory provisions enacted in the Omnibus Budget Reconciliation Act (OBRA) of 1989. The purpose of these provisions is to narrow exceptions to the direct billing requirements of the Deficit Reduction Act of 1984 which generally required payment to be made only to laboratories that actually performed the tests. The OBRA of 1989 narrowed the exception to direct billing requirements to laboratories that referred no more than 30 percent of their tests annually to another laboratory.

These amendments further narrow this exception by: (1) clarifying that laboratories which refer out more than 30 percent of the tests they are requested to perform may not continue to qualify for the direct billing exception; (2) clarifying the 12 month period for application of the 30 percent rule as the period beginning on January 1, 1991; and (3) further clarifying the exception to direct billing

for laboratories wholly owned by the entity performing referred tests.

Section 4024—Coverage of nurse practitioners in rural areas

Nurse practitioners are licensed by States and are generally permitted to provide a range of primary care services. This Committee recommended in 1989 that the services of nurse practitioners be recognized for direct payment under Part B of Medicare in those settings where the services of physician assistants were recognized. Nurse practitioners would, however, have been required to work in collaboration with a physician, rather than under the supervision of a physician. OBRA 1989 included a provision authorizing direct payment for the services of nurse practitioners, working in collaboration with a physician, provided to patients in a Medicare certified Skilled Nursing Facility or a Medicaid approved nursing facility.

The Committee recognizes that many rural communities are experiencing an acute shortage of health care professionals including physicians. Inasmuch as nurse practitioners and clinical nurse specialists are licensed to provide a number of primary care services, the Committee anticipates that enactment of this provision would help to expand the access of Medicare beneficiaries in rural communities to these critical and cost-effective services.

The Committee bill would authorize direct Medicare payments for the services of nurse practitioners or clinical nurse specialist that would otherwise be physicians' services, working in collaboration with a physician, in a rural area, effective January 1, 1991. The payment amount for such services would be 80 percent of the lesser of the actual charge or the prevailing charge (or fee schedule amount) determined for the service if performed by a physician. The prevailing charge (or fee schedule amount) for this purpose for a locality would be set at 75 percent of the prevailing charge for physicians' services provided in a hospital and 85 percent of the prevailing charge for physicians' services in other settings. All claims for such services would be required to be made only on an assignment basis.

Section 4025—Clarifying coverage of eyeglasses provided with intraocular lenses following cataract surgery

Current law provides coverage for prescription glasses for Medicare patients who have had cataract surgery. In this procedure, the natural lens of the eye is removed and an artificial, intraocular lens (IOL) is implanted. Patients also generally need prescription glasses to restore optimal visual function. Since a significant number of other Medicare beneficiaries have a need for prescription glasses which are covered only in the case of the post-cataract patient, and since the General Accounting Office has recommended withdrawal of coverage for prescription glasses for cataract patients with IOLs, the Committee understands that the Secretary is considering deletion of this benefit.

The Committee bill would authorize in the statute continued coverage for prescription glasses for the post-cataract patient, but coverage would be limited to the initial prescription following cataract surgery.

Section 4026—Coverage of injectable drugs for treatment of osteoporosis

Under current law, Medicare does not cover the costs of outpatient prescription drugs that are self-administered. Calcitonin-salmon, an FDA approved drug for the treatment of post-menopausal osteoporosis, has been shown to be effective in treating such patients who have bone fractures. Since this drug is considered self-administerable, Medicare covers only the cost of its administration for those who cannot inject themselves.

The Committee recognizes that other, effective prescription drugs are not covered under the Medicare program at this time. However, it is possible that use of this drug may retard the advance of this disease and reduce the number and length of hospitalizations and other services covered under Medicare.

The Committee bill includes a provision that would authorize payment for Calcitonin-salmon for two years on an outpatient basis only for the treatment of bone fractures in patients with post-menopausal osteoporosis who are unable to self-administer the drug, and who otherwise meet the coverage conditions for home health services under the Medicare program. The Secretary is directed to prepare a report to Congress evaluating the impact of this coverage and making such recommendations as he may deem appropriate.

Section 4027—Conditions for cataract surgery alternative payment demonstration project

The Committee has been advised that the Secretary is planning a cataract surgery payment demonstration project based on a negotiated global fee in at least three geographic areas. The proposed demonstration has raised a number of concerns in the physician community including potential threats to quality of care, limits to patient access, and inappropriate incentives to increase the volume of cataract procedures.

The Committee recognizes the value of payment demonstrations in improving administration of the Medicare program, and utilizing scarce resources more efficiently. However, the Committee wishes to caution the Secretary with respect to the conduct of this proposed demonstration. The Committee bill would require the Secretary to consider factors other than volume in selecting sites for the demonstration, to carefully monitor the quality of services provided, and to consult with practitioners specializing in this surgery and necessary follow-up care in the design of the project and selection of sites.

Section 4031—Medicare Carrier Notice to State Medical Boards

Under current law, Medicare carriers are under no obligation to refer cases of unethical or unprofessional behavior by physicians to the appropriate state medical licensing board.

The Committee bill would amend current requirements with respect to contracts between the Secretary and Medicare carriers to require that all carriers refer cases of unethical or unprofessional conduct to the state licensing board responsible for issuing the physician's license to practice. This amendment would be effective 60 days after the enactment of this provision.

PART 2—PROVISIONS RELATING TO PARTS A AND B

*Subpart A—Peer Review Organizations**Section 4101—PRO coordination with carriers*

Peer Review Organizations (PROs) and Medicare carriers that administer Part B claims under contract to the Secretary are engaged in similar activities with respect to their responsibilities for conducting utilization reviews and quality of care assessments. Both PROs and carriers employ medical review criteria, screening parameters, and profiling of practitioner patterns of practice. Both PROs and carriers are engaged in evaluating trends in the utilization of services within the areas of operation.

This Committee is anxious to encourage closer cooperation and collaboration between these entities to strengthen the Medicare program's quality assurance efforts, to control unnecessary and inappropriate utilization, and to encourage changes in practice patterns. The Committee also believes that these entities should cooperate in identifying those practitioners who should be removed from participation in the Medicare program.

Accordingly, the Committee bill would direct the Secretary to provide for information exchanges, the development of common utilization and quality review criteria, and collaboration on the analysis of utilization trends within their respective geographic areas.

Section 4202—Confidentiality of peer review deliberations

Current law provides a number of prohibitions against the disclosure of information held by Peer Review Organizations. PROs are not considered federal agencies for purposes of the Freedom of Information Act, and data or information acquired by them in the exercise of their duties may not be disclosed to any person except under specific rules set forth in the statute.

The Committee bill clarifies existing statutory provisions with respect to the protection of documents or other information produced by a PRO in connection with its deliberations concerning a recommendation to sanction a practitioner. The Committee bill would require the PRO, on the request of the practitioner adversely affected by such a recommendation, to provide a summary of its findings and conclusions.

Section 4103—Role of peer review organizations in review of hospital transfers

The Committee has been advised that in the investigation of alleged violations of patient transfer requirements imposed on hospitals under Section 1867 of the Social Security Act, the Inspector General of the Department of Health and Human Services consults with the appropriate PRO in evaluating the medical aspects of such cases. While this consultation is within the discretion of the IG, the Committee strongly believes it should be considered a part of the routine investigation conducted in these cases.

The Committee bill would require the Secretary or his designee to consult with the appropriate PRO before effecting a sanction concerning the medical condition of the patient transferred, and to provide its opinion on whether the medical benefits of the transfer

outweighed the risks of transfer. In requesting such consultation, the Secretary shall provide information and documents concerning these issues to the PRO, and shall provide a period of at least 60 days for the PRO to submit its report. The PRO shall, within the time available, provide notice of its review to the physician and/or institution involved, and offer a reasonable opportunity for discussion and the submission of additional information. The bill would permit the Secretary to omit such a consultation with the PRO where a delay would immediately jeopardize the health or safety of the public.

The Committee expects that consultations with the PRO will be the routine in the vast majority of cases. Further, the Committee anticipates that the exception for emergency circumstances will be reserved for clearly egregious violations of the patient transfer requirements.

Section 4101—Peer review notice

Current law authorizes PROs to consider cases involving violations of Medicare obligations by physicians. If the PRO determines that a violation has occurred in a substantial number of cases or a gross and flagrant violation has occurred in one case, it must recommend a sanction of the physician to the Secretary.

The Committee bill would require PROs, in cases where they have recommended a sanction to the Secretary, to report such action to the State medical board responsible for the license under which the individual is authorized to practice. In addition, the bill would direct the PRO to notify the State medical licensing board.

Section 4105—Notice to State medical boards when adverse actions taken

Under current law, the Secretary on the recommendation of a PRO may exclude a physician from participation in the Medicare and Medicaid programs because of violations of one or more obligations set forth in the statute.

The Committee bill would require the Secretary to notify the State licensing board responsible for the licensing of such physician when he excludes a physician from participation in Medicare and Medicaid.

Section 4107—Treatment of optometrists and podiatrists by peer review organizations

Current law requires PROs to utilize the services of practitioners and specialists in medicine, dentistry, and other types of health care who are engaged in the practice of their profession within the area served by the PRO. In addition, PROs may not use any person who is not a duly licensed doctor of medicine, osteopathy, or dentistry to make final determinations of denial decisions effecting the services provided by such practitioners.

The Committee bill would amend these provisions by including optometrists and podiatrists among the list of practitioners to be included in the peer review process, and permitted to make final denial determinations respecting services provided by practitioners in their specialties.

*Subpart B—Other Provisions**Section 4121—Extension of secondary payor provisions*

Under current law, individuals who become disabled and eligible to receive benefits under the Social Security Act are entitled to Medicare benefits after they satisfy a waiting period. Similarly, individuals with end stage renal disease may become entitled to Medicare benefits after an initial waiting period. In both cases, the Medicare program is a secondary payer to any private health insurance benefits that such individuals may have.

(a) *Extension of renal disease period from 12 to 18 months.*—The Committee bill would extend provisions of current law with respect to Medicare as a secondary payer to private health benefits for persons with End Stage Renal Disease. The current requirement for private coverage to remain primary for 12 months would be extended to 18 months, effective for group health plan years beginning on or after January 1, 1991.

(b) *Elimination of sunset for transfer of data provision.*—This provision of the Committee bill would extend the authority for Medicare contractors (intermediaries and carriers) to inquire of employers concerning the coverage of any group health benefits to which an individual may be eligible in order to apply the Medicare secondary payer rules more effectively.

(c) *Elimination of sunset on application to disabled beneficiaries.*—The Committee bill would extend the expiring authority for private group health benefit plans to be designated the primary payer for covered individuals who are also entitled to Medicare benefits because of a disabling condition. The sunset provision in current law of December 31, 1991 for this provision would be deleted.

Section 4122—Health maintenance organizations

(a) Current law does not permit the Secretary to make retroactive payments on behalf of enrollees in a risk contract HMO or competitive medical plan (CMP). Individuals, enrolled in an HMO or CMP through a group health plan, who desire to become Medicare risk contract enrollees may experience a delay in the notification of their enrollment to the HMO. Thus, even though an individual has ceased to be covered under the group plan, and is duly enrolled as Medicare member, the HMO cannot recover capitation payments for those periods prior to notification by the group health plan.

The Committee bill would permit retroactive payments to risk contract HMOs or CMPs for up to three months for individuals or their spouses who are enrolled in such organizations by their employer or former employer as Medicare beneficiaries.

(b) The Committee has been advised that it is possible for an employer to enroll a Medicare entitled person in a risk contract HMO and pay for the Medicare Part B premium without violating current law provisions with respect to the working aged.

The Committee bill would prohibit an employer from offering any financial inducement for an individual to terminate his/her enrollment in a group health plan offered by such employer, unless

the employer offers such incentive to all individuals eligible for coverage under the group plan.

(c) *Patient's right to participate in and direct health care decisions.*—In July 1990, the U.S. Supreme Court issued its opinion on *Cruzan v. Director, Missouri Department of Health* 110 S.C. 2841 (1990), a case in which the Court recognized a patient's right to die and endorsed the withdrawal of life support and the withholding of medical treatment in cases where a patient's wishes were known. The Court's decision provided, however, that such actions could only be carried out in situations where the patient's wishes had been made clear.

The Supreme Court's decision has served to highlight the importance and usefulness of "advanced directives" such as living wills and durable powers of attorney. These instruments—which are recognized in law by almost all States—are intended to establish an individual's preferences with respect to medical care and treatment and to help ensure that those preferences are respected. They are designed to document how an individual would like to be treated or who should make treatment decisions, if the individual should become incapacitated and lose the ability to communicate. They are, indeed, meant to serve as the documentation or proof that the Supreme Court was looking in the *Cruzan* case.

Most Americans are not aware, however, of their right to refuse medical treatment or of their right to execute an advance directive. In light of the *Cruzan* decision, it is the Committee's view that such information should be made available to adult Americans so that they can best be prepared to exercise those rights, if they choose. Section 4122(c) is designed to help meet this objective.

(1) *Requirement for eligible organizations.*—Paragraph (1) of subsection (c) requires that, as a condition for entering into a risk-sharing contract with the Secretary, a health maintenance organization or a competitive medical plan, must maintain written policies and procedures regarding the receipt of medical care by adult individuals from or through each such provider. Such policies and procedures are to include a process for providing written information to each such individual on (1) the individual's rights under State law to make decisions concerning the individual's medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and (2) the provider's written policies respecting the implementation of these rights. Such policies and procedures must also provide for documentation (in the individual's medical record) of whether or not the individual has executed an advance directive as well for assurances of the provider's compliance with the requirements of State law respecting advance directives. In addition, such policies and procedures must specify that the provision of care by the provider is not conditioned on whether or not the individual has executed an advance directive. Finally, these policies and procedures must provide for the education of staff and the community on issues concerning advance directives.

The Committee notes that primary purpose of these provisions is to ensure that adult individuals have the information they need in order to protect their legal rights to make decisions about their medical care and to execute appropriate documentation for the en-

forcement of those decisions. No individual seeking services from a health maintenance organization or a competitive medical plan is required to execute a living will or a durable power of attorney. And no such provider is required to assist any individual in formulating an advance directive. All that is required is that adult individuals be provided with information concerning applicable State law and that health maintenance organizations and competitive medical plans establish policies and procedures to ensure compliance with the law.

(2) *Application to other prepaid organizations.*—Paragraph (2) of subsection (c) requires that reasonable cost contract organizations (described in Section 1833(a)(1)(A)) meet the requirements relating to the maintenance of written policies and procedures respecting advance directives as provided under paragraph (1) of this subsection, above.

(3) *Effective date.*—Section 4122(c)(3) provides that the provisions of subsection (c) of Section 4122 shall apply with respect to services furnished on or after the first day of the first month beginning more than one year after the date of enactment.

Section 4123—Demonstration project for providing staff assistants to home dialysis patients

Current law provides for the payment of a composite rate for dialysis services rendered to patients in facilities or in their homes. Services of an aide to assist with the dialysis procedure are available on a limited basis in some centers, but for the most part, home dialysis patients do not have access to paid aide services. The Committee is aware that as a result of changes in the alternative payment method available to ESRD patients, some patients who may have come to rely on the services of a paid aide may no longer be able to afford such assistance.

The Committee notes that some home dialysis patients are non-ambulatory and have acute medical problems. Travel to dialysis centers is difficult and risky. Some are unable to dialyze themselves and have no caregiver at home to assist. The Committee is concerned about reports of persons with multiple complications being at risk without assistance, and the deaths of several dialysis patients after the loss of paid assistance.

Accordingly, the Committee bill would authorize a two year demonstration program to determine whether and under what circumstances paid assistance for routine dialysis should be permitted. Individuals participating in such a demonstration would be limited to those with a certification from the attending physician that the individual suffers from a permanent, serious medical condition that precludes travel to and from a provider of services or dialysis facility, and that there is no caregiver available in the individual's home. Payments under this demonstration would be limited to \$2 million, and the Secretary would be required to submit a report on the results of the demonstration and his recommendations.

Section 4124—Extension of reporting deadline for Alzheimer's disease demonstration project

Section 9342 of the Omnibus Reconciliation Act of 1986 (P.L. 99-509) required the Secretary to conduct at least five demonstration

projects to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services for Medicare beneficiaries who have Alzheimer's disease or a related disorder. Such projects were to be conducted over a three-year period. Upon the completion of these projects, the Secretary is to provide a final report to the Congress on the study's findings and results. Section 4124 of the Committee bill extends the time for the Secretary to report to the Congress until one year after the completion of the demonstration projects.

Section 4125—Miscellaneous technical corrections

Under the home health quality reform law (enacted as part of the Omnibus Reconciliation Act of 1987, P.L. 100-203), a home health aide training and competency evaluation program, or a competency evaluation program, may not be offered by or in a home health agency which, within the previous two years, has been determined to be out of compliance with the requirements specified in Section 1861(o) (regarding the definition of home health agency) or Section 1891(a) (regarding the conditions of participation for home health agencies). The purpose of these restrictions is to prohibit agencies which have been found (within a two-year period) to be deficient in meeting the home health agency requirements concerning patient care, from training those who are responsible for providing much of that care.

In its August 14, 1989 interim final rule to implement the 1987 reform law, HCFA specified that, under this statutory restriction, no home health agency that has been found out compliance with "one or more of the requirements of this part [42 C.F.R. Part 484 on Conditions of Participation for Home Health Agencies] within any of the 24 months before the training program is to begin" may conduct a home health training program (54 Fed. Reg. 33372). The effect of this rule, as the Committee understands it, is to preclude even those home health agencies which have committed only minor infractions of the home health agency requirements from offering training and competency evaluation programs.

In order to avoid the imposition of these restrictions in such circumstances, the Committee bill modifies the conditions under which a home health agency is precluded from offering a home health aide training and competency program, or a competency evaluation program. Under the Committee bill, a home health agency is prohibited from conducting any such program if, within the previous two years, it has been determined to be out of compliance with any of the requirements relating to home health aides or has been subject to an extended (or partial extended) survey.

The primary purpose of the 1987 home health quality reform law is to ensure that Medicare beneficiaries receive only quality home health services. Thus, in the Committee's view, an agency that has been found to have provided "substandard care" to its patients—the standard for triggering an extended or partial extended survey by a State—should not be permitted to train and evaluate nurse aides. Such an agency is clearly not the appropriate setting for training nurse aides in the proper care and treatment of disabled and often frail individuals.

In the Committee's view, too, an agency that has not met the home health aide requirements should not be allowed to offer home health aide training and evaluation programs. And agency which has failed to comply with these requirements is certainly not an appropriate place for training individuals to provide home health services and must not be permitted to pass its substandard practices.

PART 3—PROVISIONS RELATING TO BENEFICIARIES

Section 4201—Part B premium

Part B of Medicare is a voluntary program financed by premiums paid by enrollees and by general revenues of the Federal government. The premium amount is the same for all enrollees and is determined under current law by the lesser of (1) an amount sufficient to cover one-half of estimated program costs, or (2) the premium amount for the previous year increased by the percentage increase in the cost of living adjustment (COLA) provided to Social Security recipients. From 1984 through 1990, the premium was set at 25 percent of program costs. The premium in 1990 is \$28.60 per month.

The Committee bill would establish the premium for 1991 at \$30.90 as a result of increasing the 1990 premium by the estimated COLA increase and adding an additional \$1. For 1992 and each subsequent year through 1995, the premium would be set at an amount that would cover 25 percent of estimated program costs.

Section 4202—Part B deductible

Part B of Medicare requires enrollees to pay the first \$75 of the reasonable charges of covered services each year. After this annual deductible is satisfied, enrollees must pay co-insurance for covered services equal to 20 percent of the allowable charge or not more than 125 percent of the prevailing charge in any locality beginning in 1991. The \$75 annual deductible has not been adjusted since 1982.

The Committee bill would set that annual Part B deductible for 1991 and each year thereafter through 1995 at \$100.

PART 4—STANDARDS FOR MEDICARE SUPPLEMENTAL INSURANCE POLICIES

PURPOSE

The purpose of Part 4 is to improve the regulation of the Medigap market by establishing Federal simplification standards, increasing loss ratios for individual Medigap policies, providing for the enforcement of loss ratios and prohibiting the sale of Medigap policies with duplicate existing coverage. It is also intended to prevent agent abuses and to insure the elderly a better return on their premium dollars for Medigap and certain other health insurance policies. To accomplish these objectives, the bill establishes specific requirements for Medigap policies, limits sales commissions on such policies and imposes loss ratio requirements on dread disease and indemnity policies.

BACKGROUND AND LEGISLATIVE HISTORY

Current law (section 1882 of the Social Security Act) sets forth certain requirements for the regulation of Medigap policies including: 1) State adoption of standards developed by the National Association of Insurance Commission (NAIC); 2) a voluntary Federal certification program; and 3) criminal penalties for certain abusive Medigap sales practices.

Section 1882 specifically prohibits the sale of Medigap policies that substantially duplicate Medicare benefits, falsely claiming Federal certification, and mailing into a State Medigap policies that are approved by that State. It also establishes "target" loss ratio requirements (the ratio of claims paid to premiums collected), minimum benefit requirements, and filing and disclosure requirements.

The Medigap market is estimated to be a \$15 billion industry. Studies show that approximately 70%-80% of those with Medicare (in excess of 20 million individuals) also have some other type of private health insurance coverage which supplements Medicare. In view of the large number of beneficiaries purchasing such policies and the historical abuses associated with it, Medigap sales practices have been of interest to this Committee and the Congress for over a decade.

Despite current law and NAIC Medigap standards, this Committee continues to be deeply concerned by abuses in Medigap marketing practices and seriously questions whether the existing system combining voluntary State adoption with a largely inoperative Federal certification program is effective. The Subcommittees on Health and Environment, and Commerce, Consumer Protection and Competitiveness held joint hearing on June 7, 1990 to address these concerns.

The hearing considered legislation (H.R. 4840) introduced by the Honorable Ron Wyden; H.R. 4835 introduced by the Honorable Jim Moody; H.R. 4344 introduced by the Honorable Mary Rose Oakar; H.R. 4242 introduced by the Honorable Fortney Pete Stark; H.R. 3959 introduced by the Honorable Edward Roybal and Mary Rose Oakar; H.R. 2603 introduced by the Honorable John Bryant; and H.R. 355 introduced by the Honorable Robert Roe. Numerous witnesses at the hearing, including representatives of the General Accounting Office (GAO), the American Association of Retired Persons (AARP), Consumers Union and the Center for Public Representation stressed the need for additional Federal legislation to strengthen regulation of the Medigap insurance marketplace.

Based on these hearings and numerous hearings and investigations by these Subcommittees and the Subcommittee on Oversight and Investigation over the past several years, the Committee has concluded that several specific problem areas exist and must be urgently addressed by the Congress. These are consumer confusion, duplication of coverage, failure to comply with ratio standards, and continued abuses in sales and marketing practices.

At the current time, it is extremely difficult, if not impossible, for consumers to compare policies, and thus make informed decisions. The proliferation of policies and the great variations in coverage have made the Medigap market one where confusion, not

clarity, is the rule. This has resulted in the purchase of unnecessary and duplicative coverage by many seniors. The Committee believes that the simplification standards required by this legislation will go a long way to minimize this problem.

The Committee is disturbed by noncompliance with the loss ratio requirements of existing law by certain Medigap sellers.

In a July 1988 report, GAO found that for 185 hospital indemnity policies, the five-year average loss ratio was 53% and for 217 specified disease policies, the loss ratio was 58%. Further, according to GAO, "the seven largest hospital indemnity insurers (representing 77% of the total earned premiums of the 185 policies) had loss ratios ranging from 19%-65%, and the seven largest specified disease insurers (representing 76% of the total earned premiums of the policies) had loss ratios ranging from 32%-67%." GAO describes dread disease and hospital indemnity policies as being "of limited value." The Committee has grave concerns about the value of these policies and the terms on which they are sold and marketed.

The Committee also expects that the limitation on first-year sales commissions, as well as the penalties for violation of the simplification and duplication requirements, will reduce agent abuses, such as "twisting" (convincing a policyholder to switch to a more expensive policy). They will also provide better protection for consumers and provide Medigap policyholders with a fairer return on their premium dollars.

The Subcommittee mentioned above worked closely together in developing this legislation, using H.R. 4840 as the basic model for consideration.

SUMMARY OF MAJOR PROVISIONS

SIMPLIFICATION STANDARDS

The Committee bill would establish simplification standards with regard to Medigap policy benefits including uniform language, definitions and format. Specifically, it provides an opportunity for the promulgation of these standards by NAIC subject to enumerated criteria. Alternatively, in the event such standards are not promulgated, it requires the Secretary of Health and Human Services (HHS) to promulgate such simplification standards. The NAIC or the Secretary is required to consult with industry officials, consumer groups, Medicare beneficiaries and other qualified individuals in developing these standards.

The bill would also require insurers to provide a standardized summary information sheet, prior to sale, describing the policy's benefits and premium, as well as its loss ratio history for the past three years. Insurers would also be required to offer a core group of basic benefits plus common additional benefits to all prospective purchasers. The bill would specifically limit to ten the total number of different benefit packages that may be offered. The Secretary of HHS would be authorized to grant limited waivers of the simplification standards for up to a three-year period for a Medigap policy that offers new or innovative benefits.

The bill would require Medigap policies and benefits to balance the following objectives: 1) simplify the market to facilitate com-

parisons among policies; 2) avoid adverse selection; 3) provide consumer choice; 4) provide market stability; and 5) promote competition.

In order to insure compliance with these simplification standards the bill would provide a civil penalty of not more than \$25,000 for issuing or selling a Medigap policy that violate these standards.

DUPLICATION

The bill would provide civil and criminal penalties for knowingly selling a Medigap policy which duplicates a person's coverage under Medicaid or another Medigap policy. It does allow sale to a Medigap policyholder if such person indicates, in writing, that the new policy is a replacement and that their current policy will be terminated when the new policy becomes effective. The bill would increase the civil penalty from \$5,000 to \$25,000 for selling a Medigap policy to a Medicaid eligible. The bill also removes the current standard that the coverage be "substantially" duplicative. In addition, the bill would authorize a private right of action for violations of these duplication provisions.

New procedural requirements would be established by the bill with regard to the sale of Medigap policies. Specifically, insurers would be required to obtain signed, written statement from a purchaser as part of the application process. The prescribed form would indicate the purchaser's current health insurance coverage and source and whether he or she is a Medicare or Medicaid beneficiary. The document would also include a signed statement from the seller acknowledging the request for and receipt of the purchaser's statement. Violations of these requirements would result in the imposition of civil and criminal penalties.

RELATIONSHIP TO MEDICAID

The bill would require Medigap policies to provide that benefits and premiums are suspended at the option of the policyholder for any period in which the policyholder is entitled to Medicaid benefits. The bill would provide further that, if the policyholder subsequently becomes ineligible for Medicaid, the Medigap policy is automatically reinstated upon proper notification by the policyholder as to the loss of Medicaid eligibility.

GUARANTEED RENEWABILITY

The bill would require Medigap policies to be "guaranteed renewable" and would prohibit insurers from cancelling or nonrenewing a policy based on the health status of the policyholder. It also would require insurers to provide various conversion options to policyholders in the event of policy or group membership termination or replacement.

LOSS RATIOS

The bill would establish penalties and procedures to insure the enforcement of loss ratio requirements. Specifically, it would impose a civil penalty of not more than \$25,000 for selling a Medigap policy that does not meet certain loss ratio requirements. The loss ratio requirement for individual Medigap policies is raised

from 60% to 70%. Dread disease and indemnity policies are required to meet a loss ratio requirement of 60%.

The bill would also require insurers to provide States with more detailed information on loss ratios, expand access to such information, and direct GAO to conduct regular audits on insurer compliance with loss ratio requirements. It also would require credits to policyholders on a proportional basis in amounts necessary to bring the policy within the applicable loss ratio standard. Civil penalties of not more than \$25,000 for each violation of loss ratio requirements would be established.

DISCRIMINATORY PRACTICES

The bill would require insurers to offer persons reaching age 65 the opportunity, for a 6-month period, to purchase a Medigap policy without conditioning the issuance of the policy, on the health status of such persons and at a level premium. It would establish civil penalties for violations. The bill would also provide that replacement policies (for policies in effect for 6 months or longer) may not contain any new, pre-existing conditions, waiting period, elimination periods or probationary periods.

MISCELLANEOUS

The bill would prohibit first-year sales commissions in excess of 200% of renewal commissions and establish civil and criminal penalties for violations.

It also would strengthen the requirement that all Medigap policies be approved by the State in which they are sold.

It would direct the Secretary of HHS to establish a health insurance advisory service program for Medicare beneficiaries and require such program to provide information, counseling and assistance regarding Medicare, Medicaid, and Medigap policies.

Finally, the bill would require insurers seeking premium increases in Medigap policies to submit certain information to States in advance, including actuarial certification of loss ratio compliance.

Subtitle B—Medicaid Program

PART 1—REDUCTIONS IN SPENDING

Sec. 4401—Reimbursement for prescribed drugs

Under current law, States may, at their option, offer coverage for prescribed drugs. In order to qualify for Federal matching funds, drug products must be (1) prescribed by a physician or other licensed practitioner, (2) dispensed by licensed pharmacists and licensed authorized practitioners, and (3) dispensed on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records. Federal matching funds are not available for any drugs which the Secretary has determined is less than effective. States may limit the number or prescription drugs which they cover through a formulary. They may also require prior authorization with respect to any of the prescription drugs which they elect to cover.

Medicaid regulations establish aggregate limits on payments for prescription drugs. Two separate limits are used: one for multiple source drugs for which therapeutic equivalents or "generic" versions are available from more than one manufacturer, and one for all other drugs. With respect to each multiple source drug, the Health Care Financing Administration (HCFA) establishes a price limit equal to 150 percent of the estimated wholesale cost of the least expensive therapeutic equivalent. The State's total payments for all such drugs during a given period may not exceed what would have been spent if the State had paid the price limits plus a reasonable dispensing fee. The State may pay more for any particular drug so long as the total for all drugs does not exceed the aggregate limit. If the prescribing physician specifies that generic substitution is unacceptable (for example, by writing "dispense as written" or "no substitution" on the prescription), the HCFA price limits do not apply. The pharmacy must supply the brand-name drug and may be paid the full brand-name cost.

With respect to all other drugs (including multiple source drugs for which the prescribing physician has requested no substitution), aggregate statewide payments may not exceed the lesser of (a) the pharmacies' usual and customary charge to the general public and (b) the estimated acquisition (wholesale) cost of ingredients plus a reasonable dispensing fee. For most drugs, the ingredient cost is limited to the State's best estimate of what providers generally are paying for a drug.

The Budget Summit agreement dated September 30, 1990, assumed savings from the Medicaid program from reductions in payments for brand-name drugs. Specifically, the Summit agreement assumed that for single source drugs manufacturers would be limited to charging Medicaid the best price given any bulk purchaser, subject to a minimum discount of 10 percent, with savings returned to Medicaid through a quarterly rebate. On September 14, 1990, the Subcommittee on Health and the Environment heard testimony that Medicaid pays substantially more for many single-source drugs than do other large purchasers. In California, the Medi-Cal program pays \$149.08 for 100 250 mg. tablets of Ceclor, used to treat certain types of respiratory infections; the Department of Veterans Affairs pays \$58.77, a discount of 61 percent. Similarly, in the case of Tagamet, used to treat ulcers, the Medi-Cal program pays \$54.77 for 100 tablets (300 mg.), while the DVA pays \$27.65, or 49 percent less. Senator David Pryor, Chairman of the Senate Special Committee on Aging testified that large private sector purchasers, including HMOs and hospital group purchasing organizations, also receive substantial discounts.

In fiscal year 1991, Federal Medicaid payments for prescription drugs are projected by HCFA to reach \$2.8 billion. The Committee believes that Medicaid, the means-tested entitlement program that purchases basic health care for the poor, should have the benefit of the same discounts on single source drugs that other large public and private purchasers enjoy. The Committee bill would therefore establish a rebate mechanism in order to give Medicaid the benefit of the best price for which a manufacturer sells a prescription drug to any public or private purchaser. Because the Committee is concerned that Medicaid beneficiaries have access to the same range

of drugs that the private patients of their physicians enjoy, the Committee bill would require States that elect to offer prescription drugs to cover all of the products of any manufacturer that agrees to provide price rebates.

Specifically, the Committee bill would deny Federal Medicaid matching payments for the covered outpatient drugs of any manufacturer that does not enter into an agreement with the Secretary to provide specified rebates with respect to all of the manufacturer's drugs to all States on a quarterly basis. A covered outpatient drug includes all prescription drugs except those for which Medicaid payments is made as part of payment for the following services: inpatient hospital, hospice, dental, physician office visits, outpatient hospital emergency room visits, and outpatient surgical procedures.

With respect to single source drugs and innovator multiple source drugs, the amount of the rebate owed to each State would be equal to the product of (1) the difference between the average manufacturer price to wholesalers for the drug and the manufacturer's best price, and (2) the number of units dispensed. The manufacturer's best price would be the lower of (1) the lowest price available to any wholesaler, retailer, provider, nonprofit entity, or governmental entity during the quarter, or (2) the lowest price in effect on September 1, 1990, increased by the percentage increase in the consumer price index for all urban consumers. The lowest price would include cash discounts, free goods, volume discounts, and rebates, and would be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package. Prices considered by the Secretary to be merely nominal would not be included in determining lowest price. The minimum rebate with respect to single source and innovator multiple source drugs would be 10 percent of the average manufacturer's price times the number of unit prescribed. The maximum rebate would be 25 percent for the period April 1, 1991, through March 30, 1993, and 50 percent for the period April 1, 1993, through March 30, 1995. Thereafter, the rebate owed would not be subject to a maximum limit.

With respect to all covered outpatient drugs other than single source and innovator multiple source drugs, the amount of the rebate would be equal to the product of (1) 10 percent of the average manufacturer price to wholesalers during the quarter (after deducting customary prompt payment discounts) and (2) the number of units dispensed during the quarter.

Rebates would be due to each State within 30 days after the receipt by the manufacturer of information from the State regarding the total number of units of each dosage form and strength of each of the manufacturer's drugs dispensed during the quarter. In order to enable to Secretary to verify accuracy of the rebates paid, each manufacturer entering into an agreement with the Secretary would be required to report to the Secretary, on a quarterly basis, the average manufacturer price for all of its covered drugs and, with respect to single source and innovator multiple source drugs, the manufacturer's best price. The Secretary would be authorized to survey wholesalers and manufacturers that directly distribute their covered drugs to verify average manufacturer prices. Infor-

mation disclosed by manufacturers or wholesalers regarding average manufacturer price or best price would be confidential and could be disclosed only as the Secretary determines necessary to carry out this provision and to permit review by the Comptroller General or Inspector General.

The prohibition against Federal matching payments for any prescription drug sold by a manufacturer without an agreement would take effect for drugs dispensed on or after February 1, 1991, except that any agreement entered into with the Secretary before that date would be effective with respect to drugs dispensed on or after January 1, 1991.

States that elect to offer prescription drug coverage under their Medicaid programs would be required to cover all of the drugs of any manufacturer entering into and complying with such an agreement with the Secretary. This requirement would take effect April 1, 1991. As under current law, States would have the option of imposing prior authorization requirements with respect to covered prescription drugs in order to safeguard against unnecessary utilization and assure that payments are consistent with efficiency, economy, and quality of care. However, the Committee does not intend that States establish or implement prior authorization controls that have the effect of preventing competent physicians from prescribing in accordance with their medical judgment. This would defeat the intent of the Committee bill in prohibiting States from excluding coverage of prescription drugs of manufacturers with agreements—i.e., assuring access by Medical beneficiaries to prescription drugs where medically necessary.

Effective January 1, 1993, States would be required to establish a drug use review program for covered outpatient drugs in order to assure that prescriptions written for Medicaid beneficiaries are appropriate and medically necessary. In making these determinations, State would be required to use any applicable guidelines developed by the Agency for Health Care Policy and Research. Each State's drug use review program would have to include both prospective and retrospective drug review. Prospective drug review would involve the review of drug therapy before a prescription is filled or delivered, typically at the point-of-sale or point-of-distribution. Retrospective drug use review would involve the period examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse or underuse, or inappropriate or medically unnecessary care, among physicians, pharmacies, and patients, or associated with specific drugs or groups of drugs.

The Committee emphasizes that the bill is framed to achieve significant Medicaid savings with the minimum possible amount of disruption of current program arrangements. The bill would not require therapeutic substitution or in any other way alter in any way the current relationships between Medicaid beneficiaries and their physicians or their pharmacists. It would not alter the relationship between physicians and pharmacists. Nor would it alter the current payment arrangements between State Medicaid programs and pharmacists. Finally, the bill would not affect any authority States have under current law to impose prior authorization controls on prescription drugs.

Section 4402—Requiring medicaid payment of premiums and cost-sharing for enrollment under group health plans where cost-effective

Under current law, States have the option of using Federal Medicaid matching funds to purchase private health insurance coverage on behalf of Medicaid beneficiaries. It is the understanding of the Committee that at least 2 States have exercised this option: California (with respect to beneficiaries with high-cost illnesses) and New York (with respect to working poor families). Michigan has exercised this option with respect to persons with AIDS. In addition, under the Medicaid transitional coverage requirement, States may pay the premiums and cost-sharing for the employer group coverage of Medicaid beneficiaries who lose cash assistance under the Aid to Families with Dependent Children program due to earnings. The regular Medicaid coverage then "wraps around" this employer coverage during the 12-month transition period.

Private insurance coverage does not affect the eligibility of an individual for Medicaid benefits. However, private insurance coverage is treated as a third party liability, and Medicaid, as a general rule, pays only after the private insurer or self-administered plan liable for the services has paid. With respect to prenatal or preventive pediatric care, including early and periodic screening, diagnosis, and treatment (EPSDT) services for children, the State is required to pay the provider in a timely manner even where the child has private third party coverage; the State must then seek reimbursement from the insurer or plan.

The Budget Summit agreement of September 30, 1990, assumed savings of \$120 million in FY 1991 and \$1.090 billion over the next five fiscal years from a requirement that States use Medicaid funds to pay employee health premiums if cost effective. The agreement noted that "many Medicaid beneficiaries have parents or spouses who have employer health coverage that could cover family members." The agreement did not stipulate any changes regarding the operation of employer group health coverage, whether insured or self-administered, and the Committee bill does not direct that any occur.

The Committee bill would require that States establish guidelines to identify cases in which enrollment of a Medicaid beneficiary in a group health plan would be cost-effective. In establishing these guidelines, States would have to take into account that an individual may only be eligible to enroll in a group health plan during specified enrollment periods and only if other family members (who may not be entitled to Medicaid) are also enrolled simultaneously. Coverage under the group health plan resulting from enrollment under this provision would be treated as third party liability. Enrollment would cost-effective if, in the judgment of the State, the reduction in Medicaid expenditures would be likely to exceed the costs of the premiums and cost-sharing which the State would be required to pay for the group health plan coverage. Payments for premiums and cost-sharing in cases that proved not to be cost-effective would not be considered erroneous excess payments for quality control purposes.

The Committee wishes to emphasize that enrollment in group health plans under this provision would not substitute for Medicaid eligibility. The fact that an individual is enrolled in a group health plan would not, and is not intended to, change the individual's eligibility for Medicaid benefits. Instead, the resulting group health plan coverage would constitute third party liability for the beneficiary. The plan would generally pay first, except in the case of prenatal and preventive pediatric services, where the State would continue to "pay and chase." Under the bill, a group health plan would include all plans treated as group health plans under section 5000(b)(1) of the Internal Revenue Code, as well as "COBRA" continuation coverage required under the Code, the Public Health Service Act, and the Employee Retirement Income Security Act of 1974.

The Committee recognizes that many group health plans have deductible, coinsurance, and similar cost-sharing requirements that are far higher than those allowed under Medicaid law. The Committee stresses that, by enrolling a group health plan, a Medicaid beneficiary does not waive the current law protections against all but nominal cost-sharing. The Committee bill expressly requires the State to pay not just the premiums, but all deductibles, coinsurance, and similar costs that will be incurred by beneficiaries under the plans in which the State has required them to enroll to the extent that these costs may not be imposed on program beneficiaries under Federal law. Federal Medicaid matching payments would be available for these expenses.

In those cases in which the State considers enrollment cost-effective, the Committee bill would direct the States to require Medicaid applicants or beneficiaries, as a condition of eligibility, to apply for enrollment in the group health plan. In the case of a child eligible for Medicaid, this requirement would apply to the child's parent. However, if the parent fails to enroll the child, the child would not be subject to denial of loss of Medicaid eligibility.

Federal Medicaid matching funds would be available, at the State's regular matching rate, for the costs of premiums, deductibles, coinsurance, and similar expenses incurred by the State in carrying out this requirement. If all members of a family are not eligible for Medicaid and enrollment of the Medicaid eligible members is not possible without enrollment of the others, and if the State considers it cost-effective, Federal Medicaid matching payments would be available for payment of the premiums (but not deductibles, coinsurance, or similar expenses) associated with enrollment of the ineligible family members. Federal matching funds would also be available, at State option, to guarantee the enrollment of Medicaid beneficiaries in group health plans for up to 6 months, even if the beneficiaries would otherwise lose eligibility due to excess income or resources.

Under the Committee bill, hospitals, physicians, and other providers who treat Medicaid beneficiaries enrolled in group health plans would be required to accept, as payment in full, the higher or the amounts payable for the service by the State or by the plan. This prohibition against billing the beneficiary would apply even to providers who do not participate in the Medicaid program. The purpose of this requirement is to assure that Medicaid beneficiaries

who enroll are protected from balanced billing to the same extent as those beneficiaries who do not have private third party coverage. The Committee bill would also prohibit providers from charging the beneficiary or the State—but not the group health plan—amounts that would result in aggregate payments exceeding the amounts recognized under the State's Medicaid program.

This requirement would be effective January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Section 4403—Computer matching and privacy revisions

For a discussion of this provision, see House Report 101-768 (to accompany H.R. 5450).

PART 2—PROTECTION OF LOW-INCOME MEDICARE BENEFICIARIES

Section 4411—Extending Medicaid payment for Medicare premiums for certain individuals with income below 125 percent of the official poverty line

Under current law, States are required to pay Medicare premiums (including the Part A premium where applicable), deductibles, and coinsurance for elderly and disabled Medicare beneficiaries whose incomes are at or below 100 percent of the Federal poverty line and whose countable resources are at or below twice the resource standard used under the Supplemental Security Income (SSI) program (\$4000 for an individual). Federal Medicaid matching funds are available to States, at the regular matching rates for services, for these Medicare cost-sharing expenses on behalf of qualified Medicare beneficiaries. This Medicare buy-in requirement, enacted in the Medicare Catastrophic Coverage Act of 1988, is being phased in. As of January 1, 1991, almost all States will be required to provide this coverage to Medicare beneficiaries with incomes at or below 95 percent of the poverty level.

Part 3 of subtitle A of the Committee bill would increase the monthly Part B premium to \$30.90 per month in 1991, and \$46.70 per month by 1995. In addition, the bill would raise the Part B deductible from \$75 to \$100. These cost-sharing increases will have a disproportionate impact on low-income beneficiaries who are not protected under current law, especially those with incomes just below and a little above the poverty level (\$6,280 per year, or \$523 per month for an individual, \$8,420 per year or \$702 per month for a couple). In the view of the Committee, the Federal government should not ask poor and near-poor Medicare beneficiaries to bear the brunt of increases in cost-sharing obligations intended to reduce the Federal deficit.

The Committee bill would extend Medicaid coverage for Medicare Part B premiums to beneficiaries with incomes below 125 percent of the Federal poverty level and countable resources at or below twice the SSI level. Unlike qualified Medicare beneficiaries under current law, these individuals would not be entitled to have payment made on their behalf for Medicare deductibles or co-insurance. To avoid further fiscal stress on State budgets, the cost of this premium buy-in requirement would be fully assumed by the Federal government in the form of a 100 percent Medicaid matching

rate. This requirement would take effect on January 1, 1991, the date on which the Part B premium would begin to increase under Part 3 of Subtitle A of the Committee bill.

The Committee bill would also correct an anomaly in the current Medicare buy-in requirement, and avoid a similar problem with respect to the new buy-in group. Under current law, Social Security beneficiaries receive a cost-of-living adjustment (COLA) in January of each year. The Federal poverty income guidelines are also adjusted for inflation annually. However, the revision is not published before the middle of February of each year. This results in a period of at least 6 weeks during which an individual's income may increase above the previous year's poverty level due to the Social Security COLA. To resolve this matter, the Committee bill would provide that, for purposes of the buy-in of all cost-sharing or just the Part B premium, the income of a Medicare beneficiary would not include any amounts attributable to COLA increases during the first 3 months of each calendar year (assuming mid-February publication of the revised poverty income guidelines).

PART 3—IMPROVEMENTS IN CHILD HEALTH

Section 4421—Phased-In Mandatory Coverage of Children Up to 100 Percent of Poverty Level

(a) *In General.*—Under current law, States are required to offer Medicaid coverage to all children born after September 30, 1983, in families with incomes and resources below State AFDC standards, up to age 7. States are also required, as of April 1, 1990, to cover all children up to age 6 in families with incomes at or below 133 percent of the Federal poverty level. In addition, States have the option of extending coverage to all children born after September 30, 1983, in families with incomes below 100 percent of the Federal poverty level, up to age 8. With respect to this poverty level group, States have the option of applying a resource test; if they do so, the resource standard and methodology may be no more restrictive than that under the State's AFDC program. According to the Children's Defense Fund, as of July 1990, 5 states had elected to cover children to age 7 at 100 percent of the poverty level, and 14 states and elected to cover children to age 8.

As the Office of Technology Assessment documented in *Healthy Children: Investing in the Future* (1988), some preventive and other health care services for infants and children, notably newborn screening and immunizations, are cost-effective and can improve health status. Medicaid, with its early and periodic screening, diagnostic, and treatment (EPSDT) services benefit, is the major source of financing for preventive health care services for low-income children. Yet, according to the Congressional Research Service, Medicaid in 1986 reached only about half of all children in families with incomes below the poverty level; because of limited private health insurance coverage among the poor, about one third of all poor children were left with no public or private insurance coverage whatsoever (Medicaid Source Book: Background Data and Analysis (Committee Print 100-AA), p. 333).

To fill this coverage gap incrementally, the Committee bill would convert the existing option to extend Medicaid coverage to poor

children into a mandate. The bill would require States to extend Medicaid coverage to all children born after September 30, 1983, in families with incomes below the Federal poverty level (\$10,560 for a family of 3 in 1990), incrementally up to age 13. This requirement would be effective July 1, 1991, regardless of whether or not final regulations have been issued, except in Texas, when the requirement would apply on September 1, 1991. As under current law with respect to children under age 6, this requirement would also apply to a State like Arizona that provides Medicaid coverage under a waiver under section 1115 of the Social Security Act.

The effect of this requirement is to phase in, over the next 5 years, mandatory Medicaid coverage for all poor children under 13. On July 1, 1991, all States would have to cover children born after September 30, 1983, in families with incomes below the poverty level, regardless of whether the family had one parent or two, and regardless of whether the family's resources exceeded the AFDC standard. On that date, the oldest of this cohort would be nearly 7¾ years old. As these children grew older, if their families remained poor, they would continue to be entitled to Medicaid coverage. By the year 1995, all States would be required to cover all poor children under age 13. The Committee notes that States that want to extend coverage more quickly may elect, under the current law "Ribicoff child" option, to cover all children under age 21 whose family incomes and resources do not exceed AFDC levels.

Section 4422—Mandatory continuation of benefits throughout pregnancy if first year of life

Under current law, and infant born to a woman eligible for Medicaid at the infant's birth is deemed to be eligible for Medicaid. The infant remains eligible for Medicaid until the first birthday, so long as he or she is a member of the woman's household and the mother remains eligible for Medicaid. During the period the infant is deemed eligible, the mother's Medicaid number is that of the infant unless the State issues the infant a separate card.

It has come to the Committee's attention that substantial numbers of infants in families that are not receiving cash assistance under the AFDC program but are eligible for Medicaid because their incomes are below 133 percent (or, in some States, 185 percent) of the Federal poverty level are losing their Medicaid coverage when the mother loses her eligibility at the end of the 60-day post-partum period. Apparently, the mothers in these cases are not filing a new Medicaid application on behalf of the infant. As result, the infant loses the benefits of Medicaid coverage, and especially the preventive services available under the early and periodic screening, diagnosis, and treatment (EPSDT) benefit. To avoid jeopardizing the health status of low-income infants by leaving them without Medicaid coverage, the Committee bill would provide that an infant born to a Medicaid-eligible woman would remain eligible for Medicaid until the first birthday so long as he or she remained in the mother's household and the woman would be eligible for Medicaid were she still pregnant.

Under current law, States have the option of extending Medicaid coverage (through the end of the month in which the 60-day post-partum period ends) to pregnant women who, because of a change

in family income, would otherwise lose eligibility. Given the importance of continuous prenatal, maternity, and post-partum care to the health status of both the pregnant woman and the child, the Committee can see justification for allowing low-income women to lose their Medicaid eligibility during pregnancy, especially when the loss is the result of fluctuations in monthly income that are a fact of life for many working poor families. Accordingly, the Committee bill would convert the current option to a mandate. Effective January 1, 1991, all States would be required to continue Medicaid eligibility (through the end of the month in which the 60-day post-partum period ends) for pregnant women who, because of a change in family income, would otherwise lose eligibility.

Section 4423—Mandatory use of outreach locations other than welfare offices

Under current law, States have the option of accepting and processing applications for Medicaid eligibility at locations other than State or local welfare offices. (The option is in addition to the presumptive eligibility option, under which States designate certain providers to make presumptive determinations of eligibility with respect to pregnant women in order to expedite coverage for prenatal care). Many States currently station eligibility workers in hospitals, clinics, WIC clinics, and similar locations in order to enroll poor women and children in the program.

The Committee is concerned that, unless poor women and children are able to apply for Medicaid in locations other than welfare offices, many of them will be deterred from obtaining the health care coverage they need in order to receive preventive health services. The Committee bill would therefore require States to provide for the receipt and initial processing of applications for Medicaid coverage by poor pregnant women, infants, and children (whether optional or mandatory) at outreach locations other than those used for receiving and processing AFDC applications, including Medicaid disproportionate share hospitals and Federally qualified health centers. The Committee bill specifies that eligibility workers who are authorized to receive and process applications be stationed at each of these facilities and entities because they are, by definition, providers that serve large substantial numbers of low-income women, infants, and children.

The eligibility workers could be employees of the welfare agency, contractors to the agency, or employees of, or contractors to, the hospital, clinic, or other outreach location. Preferably, they would have the authority to make eligibility determinations on site. As under current law, all costs incurred by the State with respect to the receipt and processing of Medicaid applications at these locations, including the salaries and equipment costs of eligibility workers, would, under the Committee bill, be considered necessary for the proper and efficient administration of the State plan and subject to Federal matching payments at a 50-percent rate.

The Committee is concerned that the lengthy, complex application forms for AFDC eligibility can create a barrier to access for women and children who are not seeking cash assistance, but only Medicaid coverage. Much of the information relevant to eligibility for cash assistance, such as resources and family composition, are

not relevant to pregnant women and young children who are eligible for Medicaid but not AFDC benefits. The Committee bill would therefore require States to provide for the use of applications for Medicaid-only coverage at the disproportionate share hospitals, Federally-qualified health centers, and other outreach locations that the State designates under this section.

Under these requirements, the Committee expects the eligibility determination process for low-income pregnant women, infants, and children to work as follows. States would develop application forms for use at designated hospitals, health centers, and other outreach locations. These simplified forms would contain only those information requirements necessary to determine eligibility for Medicaid. This information would include verification of the woman's pregnancy; age of the child (which could be provided through methods other than a formal birth certificate, such as verification from a hospital or from a child's health care provider regarding the child's date of birth); size and income of the family; verification of lawful residence in the U.S.; information concerning third party liability; and, in the case of children only, disclosure of paternity information in circumstances where such information is applicable. States using initial intake applications that include this information would not be required to use separate applications for making final eligibility determinations.

The entire applications process would be conducted at the hospitals, health centers, and other outreach locations. If the eligibility worker at the outreach location were a welfare agency employee or contractor, the final eligibility determination could be made at that location. However, even if the eligibility worker were an employee of the hospital or clinic, the pregnant woman or child would not be required to go to the welfare office for a face-to-face interview in order to complete the eligibility determination process. Instead, the simplified application form, along with necessary documentation, would then be forwarded to the welfare office for final determination.

Both of these requirements would be effective July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Section 4424—Presumptive eligibility

Under current law, States have the option to offer coverage for ambulatory prenatal care to pregnant women who have been determined to be presumptively eligible for Medicaid. Generally, the coverage extends through a presumptive eligibility period, which ends on the earlier of (1) the date on which a final eligibility determination is made or (2) 45 days after the determination of presumptive eligibility. If a woman does not file an application for Medicaid within 14 days after being determined presumptively eligible, her coverage terminates at that point.

The purpose of this option is to avoid delays in access of low-income women to needed prenatal care while their formal applications for Medicaid eligibility are being considered. Presumptive eligibility determinations are made by certain providers of outpatient or clinic services, such as Federally-funded community health cen-

ters. According to the Children's Defense Fund, as of June 1990, 25 States had implemented the presumptive eligibility option.

(a) *Extension of presumptive eligibility period.*—It is the understanding of the Committee that the rigid timeframe under current law has discouraged some States from adopting the presumptive eligibility option, despite the obvious benefits of making medically necessary outpatient services available to low-income pregnant women during the critical prenatal period while the State processes their formal applications for full Medicaid eligibility. In order to make the presumptive eligibility option more attractive to the States, the Committee bill provides that the presumptive eligibility period ends with (and includes) the earlier of (1) the day on which a final eligibility determination is made or (2) in the case of a woman who does not file an application by the last day of the month following the month during which she is determined to be presumptively eligible, that last day. This modification is effective for ambulatory prenatal services provided on or after July 1, 1991, whether or not final regulations are issued.

This modification would have the following effect. First, the current 45-day limit on the presumptive eligibility period would be eliminated. Thus, if a State took more than 45 days to process a woman's Medicaid application, coverage for ambulatory prenatal care would continue without interruption until the day the State makes a final eligibility determination. Second, a pregnant woman would have at least one month, and as much as two months, during which to file the formal application for Medicaid coverage. Thus, if a woman was determined presumptively eligible on June 15, she would have until July 31 to file her formal Medicaid application. This will avoid the loss of presumptive eligibility solely because a low-income pregnant woman is unable to meet the current 2-week deadline for filing what can (but should not) be a complicated eligibility form.

(b) *Flexibility in application.*—It is the understanding of the Committee that a number of States have been advised by the Health Care Financing Administration that they must use different application forms for presumptive eligibility determinations and for final Medicaid eligibility determinations. There is no basis for this assertion. The Committee bill clarifies that a State has, and always has had, the option to use the same application form for presumptive eligibility purposes as it uses to determine final Medicaid eligibility for pregnant women.

Section 4425—Role in paternity determinations

Under current law, States must require all applicants for Medicaid, as a condition of eligibility, to cooperate with the State in establishing paternity and in obtaining child support. The State may waive this requirement if it determines that the individual has good cause for refusing to cooperate.

The Committee is concerned that application of these requirements to women who are applying only for pregnancy-related coverage may discourage many of them from seeking benefits that would give them access to early prenatal care. The Committee notes that the Department's own manuals acknowledge that paternity determinations, which are based on one of several blood tests,

cannot be made before an infant is at least 4 months old: "Blood must be drawn in sufficient quantity for the particular test to be performed. . . . This may impose a mandatory delay in a case involving a newborn infant because it is difficult to obtain any significant volume of the baby's blood. Many technicians require that a child be four to six months old and be in good health before they will attempt to obtain a blood sample. . . . Some laboratories will not draw blood for [one type of] testing unless the child is at least 12 months old. For the other tests [for paternity determination], it is generally prudent to avoid venipuncture until the child is 6 months old. An additional advantage in waiting this long after birth is the assurance that antigens in the blood are fully developed by this age." U.S. Department of Health and Human Services, Office of Child Support Enforcement, *A Guide for Judges in Child Support Enforcement* (1983) at pages 51-52.

Thus, the cooperation requirement is not only a potential barrier to prenatal care for the high-risk, low-income women that would most benefit from it, but it is also a bureaucratic hurdle that yields absolutely no useful information until months after the prenatal period has ended. The Committee bill therefore exempts pregnant women applying for Medicaid on the basis of their pregnancy and low income from the cooperation requirements with respect to establishing paternity and obtaining child support. The provision is effective on enactment.

Section 4426—Report and transition on errors in eligibility determinations

Under current law, States are required to review the accuracy of eligibility determinations. Under this so-called "quality control" (QC) process, the State selects a monthly sample of cases for review and identifies cases where errors (other than technical errors) have resulted in payments for services on behalf of individuals who were not eligible or whose "spenddown" liability was underestimated. The State's error rate is the ratio of the Medicaid funds spent as a result of the error to the Medicaid funds spent for the entire sample. If this rate exceeds 3 percent, the State is subject to a reduction in Federal matching payments, unless the Secretary waives the disallowance because the State has made a good faith effort to comply. Expenditures for ambulatory prenatal care to pregnant women during a presumptive eligibility period are excluded from the calculation of erroneous payments.

The Committee is concerned that the QC process has had an inadvertent chilling effect on the ability of low-income pregnant women and infants to establish promptly eligibility for Medicaid. As currently structured, the QC process focuses on penalizing States for extending coverage to individuals who are not eligible. The process does not impose penalties for erroneous denials of coverage to individuals who are in fact eligible. Thus, States have a strong incentive to establish the most stringent, time-consuming eligibility determination and verification procedures. States have no incentive to correct those procedures when they result in the delay or denial of coverage to individuals who are in fact eligible.

In the view of the Committee, payment accuracy is an important goal of the Medicaid program, but it is not the only goal. A funda-

mental purpose of Medicaid is to improve the health status of the poor by assuring access to needed health care. One of the principal measures of health status is infant mortality. The Committee is concerned that the QC process may be deterring States from making eligibility determinations in a timely and expeditious manner. Unnecessarily lengthy eligibility determination procedures are inconsistent with the program's objective of increasing access by low-income pregnant women and infants to needed prenatal, maternity, and well-child services in a timely manner.

The Committee bill would require the Secretary to report to Congress, by not later than July 1, 1991, on error rates by the States in determining Medicaid eligibility of pregnant women and infants. In addition to information from the current QC system, the report should contain information on the extent to which States erroneously deny or delay eligibility to pregnant women and infants who are in fact eligible for coverage. The report should also include recommendations for reducing the amount of time required by States to make accurate eligibility determinations with respect to these populations. To reduce the adverse incentives of the QC process while the Secretary studies this issue, the Committee bill would exclude from the calculation of error rates any Medicaid expenditures attributable to pregnant women and infants made during the period beginning on July 1, 1989 and ending the first calendar quarter beginning more than 12 months after the Secretary submits the report.

PART 4—NURSING HOME REFORM PROVISIONS

Section 4431—Medicaid nursing home reform

(a) *Nurse aide training.*—Under the Omnibus Reconciliation Act of 1986 (OBRA '87), effective October 1, 1990, all nurse aides used by nursing facilities participating in Medicaid must (1) have completed, within four months, a training and competency evaluation program approved by the State; and (2) be competent to provide nursing-related services.

OBRA '87 required the Secretary to establish requirements for State nurse aide training and competency evaluation programs and State nurse aide competency evaluation programs by September 1, 1988. Pending the publication of regulations establishing such requirements, HCFA issued a guidance document, effective May 12, 1989 (HCFA Transmittal No. 62, Sections 2504-2512 (April 1989)), which set out approval criteria for the States. This delay resulted, in some instances, in States postponing either the development of appropriate training and evaluation programs or the approval of qualified training and evaluation programs that were already in operation. It resulted, too, in confusion among the States, nurse aides, and the nursing home industry.

On March 23, 1990, the Secretary issued proposed regulations regarding the implementation of the State nurse aide training and competency evaluation requirements (55 Reg. 10938-10951). Those proposals, although not final, have also caused some confusion and created some difficulties for the States, nurse aides, and the nursing home industry in their efforts to continue to carry out these requirements.

In response to these concerns, the Committee bill contains a number of provisions designed to clarify the structure and operation of the OBRA '87 nurse aide training and competency evaluation requirements.

(1) *No compliance actions before effective date of guidelines.*—In response to the confusion that has resulted from HCFA's delay in publishing regulations relating to nurse aide training and competency evaluation programs, and to nurse aide competency evaluation programs, the Committee bill prohibits the Secretary from taking any compliance action against any State that has made a good faith effort, prior to May 12, 1989 (the effective date of HCFA's interpretative guidelines), to comply with these OBRA '87 requirements. Such efforts would include a State's approval (prior to May 12, 1989) of a nurse aide training and competency evaluation program which the State had reasonably believed, at the time it made its certification, was in compliance with the OBRA '87 requirements. However, for periods occurring after May 12, 1989, and until HHS nurse aide training regulations are effective, the Committee intends for States to meet fully, the requirements of the statute, as specified in HCFA's May 1989 guidance document (as periodically updated).

In providing for this good faith exception, the Committee emphasizes that the Secretary's past failure to implement the OBRA 1987 nurse aide training and competency evaluation provisions through final regulations, while regrettable, should not be construed to undermine the validity of the requirements specified in HCFA's May 12, 1989, interpretative guidelines. OBRA 1987 did not mandate that the Secretary issue such regulations and explicitly did not predicate implementation of the nurse aide training and competency evaluation requirements upon the issuance of final regulations.

(2) *Clarification of grace period for nurse aide training of individuals.*—Under OBRA '87, effective October 1, 1990, a nursing facility participating in Medicaid may not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide for more than a four-month period unless the individual has completed an approved nurse aide training program and competency evaluation program, or a competency evaluation program, and is determined to be competent to provide nursing-related services.

The Committee bill simply clarifies what Congress had originally intended in enacting the OBRA '87 requirements relating to the use of nurse aides: no individual may work as a nurse aide for more than 90 days at any point in his or her career without having completed an approved nurse aide training and competency evaluation program, or a competency evaluation program, and without having demonstrated competency to provide nursing and nursing-related services. This requirement applies whether such an individual is an employee of a nursing facility or is a per diem worker from an agency pool.

For example, an individual may perform nurse aide work as an employee of nursing facility "A" for 70 days, then quit and obtain employment at nursing facility "B". Under the Committee's bill, it is now clear that this individual could be used as a nurse aide at facility "B" (or any other nursing facility) for only 20 days without having completed an approved training and competency evaluation

program, or a competency evaluation program, and without having demonstrated competency to provide services. Similarly, an individual employed by an agency (or as an independent contractor) who works 15 days at nursing facility "A", 15 days at nursing facility "B", 15 days at nursing facility "C", and 45 days at nursing facility "D", may not be used as a nurse aide by any other nursing facility until he or she has completed an approved training and competency evaluation program, or a competency evaluation program, and has demonstrated competency to provide services.

The Committee bill includes this clarification not only to explain its purpose in enacting the OBRA '87 requirements regarding the use of nurse aides, but also to stress its intent that the 90-day exemption from the training and competency evaluation requirements is only a grace period, not a "loophole" for circumventing the law.

(3) Clarification of Nurse Aides Not Subject to Charges.—In 1989, Congress amended OBRA '87 to prohibit the imposition on nurse aides of any charges relating to either nurse training and competency evaluation programs, or to competency evaluation programs (P.L. 101-239). In establishing this prohibition, Congress intended that it be applied with respect to nurse aides who were already employed by a nursing facility or who already had an employment arrangement with a nursing facility.

It is the Committee's understanding, however, that in some States, this requirement has been put into place for individuals who have been enrolled in a nurse aide training program (sponsored by a community college, for example), but who have not yet sought employment in a nursing facility. While such individuals, after the completion of their training program, may chose to work as a nurse aide in a nursing facility, they may also elect to find employment in another type of health care setting such as a hospital or home health agency. Congress did not intend in 1989 to prohibit the imposition of nurse aide training and competency evaluation charges and costs on individuals who plan to work in settings other than a nursing facility.

Thus, the Committee bill clarifies that the prohibition against nurse aide training and competency evaluation charges is applicable only to nurse aides who are employed by (or who have entered into an employment agreement with) a nursing facility. The Committee notes that such an agreement is not limited to a formal written employment contract, a legal arrangement which many nurse aides do not ususally have with a nursing facility. Rather, in the view of the Committee, any written or oral communication which indicates that an individual is to work as a nurse aide at a specific nursing facility would constitute such an employment agreement.

(4) Modification of nursing facility deficiency standards.—Under OBRA 1987, a State-approved nurse aide training and competency evaluation program, or a competency evaluation program, may not be offered by or in a nursing facility which, within the previous two years, has been determined to be out of compliance with the requirements of OBRA 1987 relating to the provision of services (Section 1919(b)), residents' rights (Section 1919(c)), or administration (Section 1919(c)). The purpose of these restrictions is to prohib-

it facilities which have been found (within a two-year period) to be deficient in meeting the requirements of OBRA 1987 that concern resident care, from training those who are responsible for providing much of that care.

In its March 23, 1990 proposed regulations, HCFA specified that, under this statutory restriction, no facility that has been found out of compliance with "any of the requirements for participation in part 483 subpart B [42 C.F.R. 483 relating to Requirements for States and Long-Term Care Facilities]" within any of the previous 24 months may conduct a nurse aide training and competency evaluation program, or a competency evaluation program (55 Fed. Reg. 10949). The effect of this proposed regulation, as the Committee understands it, is to preclude even those nursing facilities which have committed only minor infractions of the OBRA 1987 requirements from offering training and competency evaluation programs.

In order to avoid the imposition of these restrictions in such circumstances, the Committee bill modifies the conditions under which a nursing facility is precluded from offering a nurse aide training and competency evaluation program, or a competency evaluation program.

Under the Committee bill, a nursing facility is prohibited from conducting any such program if, within the previous two years, it has operated under a waiver of the nurse staffing requirements (established under Section 1919(b)(4)(C)(ii) or has been subject to an extended (or partial extended) survey (required under Section 1919(g)(2)(B)).

As stated in the Conference Report to accompany OBRA 1987, the primary purpose of the nursing home reform law is to ensure that nursing facility residents receive only quality care. Thus, in the Committee's view, a facility that has been found to have provided "substandard care" to its residents—the standard for triggering an extended or partial extended survey by a State—should not be permitted to train and evaluate nurse aides. Such a facility is clearly not the appropriate setting for training nurse aides in the proper care and treatment of frail and disabled residents.

In the Committee's view, too, a facility that has not met the OBRA 1987 nurse staffing requirements should not be allowed to offer nurse aide training and evaluation programs. Nurse aides are hired to assist professional nurses in providing nursing and nursing-related services to residents. A facility which has no professional nurses on staff or only a limited number (because the facility has been granted a waiver of all or part of the nurse staffing requirements) is not, therefore, an appropriate place for training nurse aides in carrying out these responsibilities.

(5) Clarification of State responsibility to determine competency.— Under OBRA 1987, States are specifically required to make determinations about the competency of individual nurse aides to provide nursing and nursing-related services. OBRA 1987 also specifically prohibits States from delegating this responsibility to a nursing facility. It has come to the attention of the Committee, however, that some States may be circumventing this prohibition by entering into subcontracts with nursing facilities (or entities related to nursing facilities) to carry out the States' responsibility to make nurse aide competency determinations. Under the Committee bill,

such subcontracts (or any other legal device designed to relieve a State directly or indirectly of its duty to conduct nurse aide competency evaluations), are specifically prohibited.

(6) *Effective date.*—All of the amendments made with respect to the OBRA 1987 nurse aide training and competency evaluation requirements are to take effect as if they were included in the enactment of OBRA 1987.

(b) *Preadmission screening and annual resident review.*—The preadmission screening and annual resident review (PASARR) process established under OBRA '87 has two components: (1) preadmission screening; and (2) annual resident review. This process is intended to prevent the inappropriate placement of individuals with mental illness or mental retardation in nursing facilities. It is also intended to ensure that Federal funds are not used to pay for inappropriate nursing facility care.

Under OBRA 1987, prior to admission to a nursing facility, States are required to screen all individuals (including those eligible for Medicare and those using private, personal funds or private long-term care insurance) with mental illness or mental retardation to determine whether they require the level of services provided by a nursing facility. Effective January 1, 1989, nursing facilities participating in Medicaid may not admit an individual with mental illness or mental retardation who has been determined by the State not to require such care.

OBRA 1987 also requires States to review on an annual basis, all residents (including those eligible for Medicare and those using private, personal funds or private long-term care insurance) with mental illness or mental retardation to determine whether nursing facility placement continues to be appropriate. The first round of these annual reviews was to be completed by April 1, 1990. Individuals who have resided in nursing facilities for less than 30 months and who are determined not require nursing facility care must be discharged in an orderly manner. The Secretary has been authorized to approve, prior to April 1, 1989, State alternative disposition plans (ADPs) for the implementation of these requirements. It is the Committee's understanding that HCFA has approved ADPs for almost all 50 States.

The law exempts individuals with a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) from both components of the PASARR process.

OBRA 1987 directed the Secretary to issue, by not later than October 1, 1988, minimum criteria for States to use in making PASARR determinations. Pending final regulations, HCFA issued a series of draft guidelines, culminating in interim guidelines, effective May 26, 1989 (HCFA Transmittal No. 42, Sec. 4250-4253 (May 1989)) for States to use in implementing these requirements. In some instances, this delay has resulted in confusion and difficulty in implementing the PASARR requirements.

On March 23, 1990, the Secretary issued proposed regulations regarding the implementation of the PASARR requirements (55 Fed. Reg. 10951-10981). Those proposals, although not final, have also caused some confusion and created some difficulties for the States and the nursing home industry in their efforts to continue to carry out these requirements.

In response to these concerns, the Committee bill contains a number of provisions designed to clarify the structure and operation of the PASARR requirements. The Committee emphasizes, however, that while the bill makes some adjustments in the OBRA 1987 requirements, it has not changed or in any way modified, its view on the need for these provisions. Indeed, the Committee reaffirms its position that these requirements are fundamental for the protection of individuals with mental illness or mental retardation against inappropriate institutionalization.

The Committee notes further that, despite delays in the Secretary's issuance of final regulations, the implementation of the OBRA 1987 PASARR requirements is already well underway in the States. For example, in a June 1989 letter to the Chairman of the Health and Environment Subcommittee, the National Mental Health Association, on behalf of itself and seven other national organizations (including the National Association of State Mental Health Program Directors and the National Association of State Mental Retardation Program Directors) informed the Subcommittee that many individuals have already been through the screening process, and that States are addressing the need for alternative community-based services for those found not to need nursing facility care. These organizations conclude that "the PASARR process is vitally important for people with mental retardation and related conditions and with mental illness". The Committee agrees and does not intend, through the provisions related to OBRA 1987 PASARR requirements discussed below, to disrupt, delay, or interfere with this implementation process in any way.

(1) *No compliance actions before effective date of guidelines.*—As noted above, OBRA '87 directed the Secretary to issue, by not later than October 1, 1988, minimum criteria for States to use in making PASARR determinations. In response to the confusion that has resulted from HCFA's delay in publishing final regulations related to the PASARR requirements, the Committee bill prohibits the Secretary from taking any compliance action against any State that has made a good faith effort, prior to May 26, 1989 (the effective date of HCFA's interpretive guidelines), to comply with these requirements. However, for periods occurring after May 26, 1989, and until final PASARR regulations are in effect, the Committee intends for States to meet fully, the OBRA '87 PASARR requirements, as specified in HCFA's guidance document (as periodically updated).

In providing for this good faith exception, the Committee emphasizes that the Secretary's past failure to implement the OBRA '87 PASARR provisions through regulation, while regrettably, should not be constructed to undermine the validity of the requirements specified in HCFA's May 26, 1989, interpretative guidelines. OBRA '87 did not mandate that the Secretary issue regulations and explicitly did not predicate implementation of the PASARR requirements upon the issuance of final regulations.

(2) *Clarification with respect to admissions and readmission from a hospital.*—Under OBRA 1987, all individuals with mental illness or mental retardation (with the exception of (1) those persons with a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) and (2) those persons who have resided in a

nursing facility for 30 months or longer) are subject to the PASARR requirements. Since the preadmission screening requirements were put into place on January 1, 1989, however, the committee has learned that, in some instances, the screening process is being inappropriately applied. Thus, the Committee bill establishes two exceptions to the preadmission screening component of the PASARR requirements. No changes are made, however, to the annual resident review component.

The first exception clarifies that nursing facility residents (that is, those individuals who have already been admitted to a nursing facility) who are being readmitted to the nursing facility after a hospital stay are not subject to the preadmission screening requirements. Since these individuals have already been admitted to a nursing facility (and, in appropriate cases, have already met the applicable preadmission screening requirements), it was never intended for such individuals to undergo a second screening upon their readmission to the nursing facility. The Committee bill makes this explicit in the law.

The second exception applies to individuals who seek admission to a nursing facility directly from a hospital and who are expected to remain in the facility only briefly. Under this exemption, and individual (1) who is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital; (2) who requires nursing facility services for the condition for which he or she received care in the hospital; and (3) whose attending physician has certified, before admission to the nursing facility, that he or she is likely to require less than 30 days of nursing facility services, is not subject to the preadmission screening requirements. Such an individual must meet all three of these conditions in order to be eligible for the exemption. Thus, for example, an individual who has been hospitalized with a stroke; who seeks admission, directly from the hospital, to a nursing facility for facility services required for treating the effects of the stroke; and who is certified by his or her physician to need no more than 30 days of nursing facility care for such services, is not required to undergo a preadmission screen under the committee's bill. However, should this individual have a mental illness or mental retardation and remain in the nursing facility beyond 30 days, he or she is still subject to PASARR's annual resident review process.

(3) Delay in application to private pay residents.—Under OBRA 1987, both components of the PASARR requirements—the preadmission screening and the annual resident review—apply to all individuals with mental illness or mental retardation who seek admission to a nursing facility, regardless of their source of payment for services. The Committee bill delays the application of each of these requirements with regard to so-called “private pay” individuals (that is, those individuals who, at the time of their admission, are not entitled to Medicaid services) until they establish eligibility for Medicaid. If a private pay individual never qualifies for Medicaid, these requirements would not apply.

With respect to the application of the preadmission screening requirements, the Committee bill postpones the timing of the screening for a private pay individual with mental illness or mental retardation from the time at which he or she seeks admission to a

nursing facility until the time at which he or she establishes Medicaid eligibility for nursing facility services. At that juncture, as the Committee bill provides, such individual must undergo, within a 24-hour period, a preadmission screening (just as any other non-private pay person is required to do in order to be admitted to a nursing facility). If as a result of the screening, it is determined that the individual does not require nursing facility services, the individual cannot remain in, or be admitted to, the facility.

With respect to the application of the annual resident review requirements, the Committee bill also postpones the timing of the review for a private pay individual with mental illness or mental retardation until the time at which the individual establishes Medicaid eligibility for nursing facility services. Once the individual becomes Medicaid eligible, he or she is subject to a resident review at least once a year. Again, should it be determined on the basis of such review that the individual does not require nursing facility services, the current annual resident review requirements are to be applied and the individual must be discharged from the nursing facility (unless he or she has resided in the facility for 30 months or more).

The Committee emphasizes that the bill delays the application of OBRA '87's PASARR requirements to private pay residents until they become eligible for Medicaid. It does not, however, exempt them from these requirements altogether (unless they have a primary diagnosis of dementia, including Alzheimer's disease or a related disorder). Thus, the Committee reaffirms its conviction that individuals with mental illness or mental retardation who do not require nursing facility services should not reside in nursing facilities. This principle applies whether an individual is Medicaid eligible or not.

The purpose of the OBRA '87 PASARR requirements is to assure that an independent determination is made of an individual's need for institutional placement. The Committee bill simply postpones this determination until the point at which the individual becomes eligible for Medicaid. Thus, unless a State has its own preadmission screening and resident review requirements, individuals would be free to spend their own resources on nursing facility care. However, upon qualifying for Medicaid, an individual is subject to the program's interest in appropriate placement and appropriate expenditures of funds, and must, therefore, undergo the PASARR process.

In light of these modifications to the PASARR requirements, the Committee does not believe it is appropriate to impose sanctions on those States which have failed, since January 1, 1989 (the date on which PASARR's preadmission screening component went into effect), to screen private pay individuals for admission to a nursing facility participating in Medicaid. Accordingly, the Committee bill prohibits the Secretary from taking such actions under these circumstances. The Secretary must, however, impose and continue to impose sanctions on those States which have failed to demonstrate (to the satisfaction of the Secretary) that they have made a good faith effort to comply, between January 1 and May 26, 1989 (the date on which HCFA's PASARR interpretative guidelines went

into effect), with all other PASARR requirements (see Section 4431(b)(1), above).

The Committee is aware that a number of States have developed their own preadmission screening programs that require a review of all individuals who seek admission to a nursing facility participating in Medicaid—regardless of their source of payment. The Committee, in including the provisions described above, has no intention of disruption or interfering with the operation of such programs or of changing such programs' standards for admitting, retaining, or making payment for, residents of nursing facilities participating in Medicaid. Thus, the Committee bill expressly states that these changes to the PASARR provisions of OBRA '87 are not to be construed as prohibiting States from developing and conducting preadmission screening programs which screen and periodically review all applicants and residents including those that are private pay.

(4) Denial of payments for certain residents not requiring nursing facility services.—Under current Medicaid law, no Federal matching payments may be made for covered services which are not medically necessary. Such services include those provided by a nursing facility.

One exception to this principle was established in OBRA 1987. It provides that individuals with mental illness or mental retardation who have resided in a nursing facility for 30 months or more may elect to remain in such a facility even though they do not require nursing facility services. Under these circumstances, a State cannot be denied Federal matching payments for reimbursement to a nursing facility for any services provided to these individuals.

The Committee bill simply clarifies that (with the exception of those residents who meet the requirements of the 30-month rule described above), no Federal Medicaid matching funds are available for nursing facility care furnished to any individual who does not require the level of services provided by a nursing facility.

The Committee recognizes that, under current law, some persons who are eligible for Medicaid are not subject to the OBRA 1987 preadmission and annual resident review determinations which indicate whether individuals require the level of services provided by a nursing facility. The Committee expects, however, that with respect to these individuals, States will use other utilization review methods designed to assure that Federal Medicaid matching funds are not paying for nursing facility services that are not required.

(5) No Delegation of authority to conduct screening and reviews.—Under OBRA 1987, State mental health and mental retardation authorities are required to conduct both components of the PASARR process and to make independent determinations about the nursing facility needs of individuals with mental illness or mental retardation. Although OBRA 1987 did not specifically prohibit States from delegating these responsibilities to nursing facilities themselves, it was never the law's intention to allow facilities to be able to conduct these activities. Since nursing facilities have a direct interest in the eligibility determinations that are to be made for those individuals subject to the PASARR requirements, there is a potential conflict of interest in permitting them to make these determinations. Thus, it was the Committee's view in 1987—as it is today—to

prohibit nursing facilities (or any of their related entities) to participate, in any way, in the PASARR process.

It has come to the attention of the Committee, however, that some State mental health and mental retardation agencies (or other appropriate State authorities) may be circumventing the intent of OBRA 1987 that PASARR determinations be made independent of a nursing facility by entering into subcontracts with nursing facilities (or related entities) to carry out the State's responsibility with respect to the PASARR requirements. Under the Committee bill, such subcontracts (or any other legal device designed to relieve a State directly or indirectly of its duty to perform the PASARR requirements), are specifically prohibited.

(6) *Annual reports.*—OBRA 1987 authorized the Secretary to approve, prior to April 1, 1989, State alternative disposition plans (ADPs) designed to relocate nursing facility residents determined under PASARR's annual resident review component, to require "specialized services" (see Section 4431(b)(9) below), but not to require the level of services provided by a nursing facility. Such plans have been approved by the Secretary for almost all 50 States. Under the Committee bill, each of these States is required to report to the Secretary, on an annual basis, on the number and disposition of the nursing facility residents covered under the State ADP. In meeting this requirement, the Committee intends that the Secretary require States with ADPs in effect to provide information on the age of each individual covered under a State's ADP, the type or types of "specialized services" required by each such individual, and the type of facility or community setting to which each such individual has been (or will be) relocated.

OBRA 1987 also requires that the Secretary report to Congress, on an annual basis, on the extent of nursing facility compliance with the requirements of OBRA 1987 and on the number and type of Federal and State enforcement actions taken under the law. The Committee bill provides that the Secretary's annual report also include a summary of the States' information (as specified above) on approved ADPs.

(7) *Revision of alternative disposition plans.*—OBRA 1987 does not provide for any revisions in a State's alternative disposition plan (ADP) once it has been approved by the Secretary. Under the Committee bill, subject to the approval of the Secretary, a State with an approved ADP is authorized to revise or amend, before October 1, 1991, its approved ADP. The Secretary may approve such a revision or amendment, however, only if the revised agreement provides that all residents covered under the agreement who do not require nursing facility services, are discharged from the facility no later than April 1, 1994 (five years after the initial deadline for filing ADPs). Thus, the Committee bill gives States the opportunity to revise their approved ADPs in light of the information resulting from the initial sets of annual resident reviews.

(8) *Definition of "mentally ill."*—In establishing the requirements for those individuals who are subject to the PASARR process, OBRA 1987 defined "mentally ill" individuals to include those "with a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition [DMS III])" and to exclude those with a "primary diag-

nosis of dementia (including Alzheimer's disease or a related disorder)". At the time this definition was developed and adopted by the Congress, there was general agreement that a reference to DSM-III was the most appropriate and the most widely recognized way to identify the population at risk of inappropriate institutionalization.

Because of its very breadth, however, much confusion has arisen over the implementation of definition of the term "mentally ill". To avoid any further difficulties, the Committee bill modifies the definition of mental illness from "a primary or secondary diagnosis of mental disorder (as defined in DSM-III)" to a "serious mental illness as defined by the Secretary." In developing this definition, however, the Committee intends that the Secretary refer to the term "serious mental illness" as that term is defined and used in the Community Support Program operated under the National Institute of Mental Health.

The Committee notes that in making this modification, there is no intention to include any changes to that part of the OBRA '87 definition of mental illness which excludes individuals with "a primary diagnosis of dementia (including Alzheimer's disease or a related disorder)". Such individuals remain exempt from both aspects of the PASARR process.

(9) *Substitution of "specialized services" for "active treatment."*—Under OBRA '87, State mental health and mental retardation authorities are not only required to determine if an individual with mental illness or mental retardation requires the level of services provided by a nursing facility; such authorities are also required to determine if these individuals require "active treatment" for these conditions. OBRA 1987 defined the term "active treatment" to have as its meaning, a definition developed by the Secretary. However, the law specifically excluded from such a definition, those services within the scope of services that a nursing facility must provide or arrange for its residents under the OBRA '87 requirements relating to the provision of services and activities.

In response to some confusion that has arisen over the development of an appropriate definition of this term, the Committee bill clarifies, that for the purposes of meeting the OBRA '87 PASARR requirements, the term "active treatment" does not necessarily have the same meaning as it does for the purposes of meeting the Medicaid requirements for intermediate care facilities for the mentally retarded (ICF/MR). Thus, the Committee bill substitutes the term "specialized services" for the term "active treatment". As under current law, the term "specialized services" is to be defined by the Secretary. And like current law, the Secretary cannot define "specialized services" to include those services within the scope of services that a nursing facility must provide or arrange for its residents under the OBRA '87 requirements relating to the provision of services and activities.

(10) *Effective dates.*—The Committee bill provides that, with some exceptions to Section 4431(b), all of the amendments with respect to the OBRA '87 PASARR requirements are to take effect as if they were included in the enactment of OBRA '87. With respect to the amendments made under Section 4431(b)(3) (relating to delay in application to private pay residents); Section 4431(b)(5) (relating

to no delegation of authority to conduct screening and reviews); Section 4431(b)(7) (relating to revision of alternative disposition plans); and section 4431(b)(9) (relating to substitution of "specialized services" for "active treatment"), the bill provides that these modifications are to take effect on the date of the enactment of this Act, without regard to whether or not regulations to implement these modifications have been promulgated by the Secretary.

(c) *Enforcement process.*—OBRA '87 established an improved enforcement process under which specified remedies are to be imposed on nursing facilities found out of compliance with the OBRA '87 requirements. Among the remedies that States are required to have in place for this purpose are civil money penalties, denial of Medicaid payments, the appointment of temporary management, and the authority to close a nursing facility or to have its residents transferred to another facility.

Under OBRA 1987, the Secretary was required to provide guidance to the States, by regulation, on the establishment of these remedies under State law (whether by statute or regulation) by not later than October 1, 1988. The States, in turn, were required to have these remedies in place by October 1, 1989. OBRA '87 explicitly did not, however, predicate implementation of these State remedies upon the issuance of final regulations.

To date, so regulations have been promulgated by the Secretary with respect to the OBRA '87 enforcement process. Nor has any guidance been provided by HCFA to the States on the implementation of this process.

In response the confusion that has resulted from the Secretary's delay in publishing regulations relating to the establishment of remedies, the Committee bill prohibits the Secretary from taking any compliance action against any State that has made a good faith effort, prior to the effective date of guidelines issued by the Secretary on such remedies, to comply with the OBRA '87 enforcement requirements.

In providing for this good faith exception, however, the Committee emphasizes that the Secretary's past failure to implement the OBRA '87 enforcement provisions through regulation, while regrettable, should not be construed to undermine the validity of those provisions. OBRA '87 explicitly did not predicate implementation of the enforcement process requirements upon the issuance of final regulations. States are still required, therefore, to establish remedies in law and to impose them on non-complying nursing facilities in accordance with the enforcement provisions of OBRA '87.

(d) *Supervision of health care of residents of nursing facilities by nurse practitioners and clinical nurse specialists acting in collaboration with physicians.*—Under OBRA '87, nursing facilities must require that the health care of every resident be provided under the provision of a physician. Under HCFA's February 2, 1989 final rule with comment (which became effective October 1, 1990), such supervision includes periodic visits by a physician to each nursing facility resident (54 Fed. Reg. 5368). The Committee bill makes minor modifications to these requirements.

(1) *In general.*—Current Medicaid law allows States to pay for care provided by licensed practitioners, including nurse practitioners and clinical nurse specialists, within the scope of their practice

as defined by State law. The Committee bill gives the States the option of paying nurse practitioners or clinical nurse specialists, working in collaboration with a physician, to conduct the periodic visits to nursing facility residents required under OBRA '87. States may exercise this option, however, only with respect to a nurse practitioner or clinical nurse specialist who is not an employee of the facility in which the resident being visited, resides.

The Committee notes that in establishing this option, it does not intend to restrict in any way the right of nursing facility residents to choose a personal attending physician, or the freedom of Medicaid beneficiaries to choose a nurse practitioner or clinical nurse specialist.

(2) *Effective Date.*—This option is to take effect October 1, 1990 without regard to whether or not final regulations to carry out the option have been promulgated by the Secretary.

(e) *Other amendments*

(1) *Assurance of appropriate payment amounts.*—As this Committee recognized in the report to accompany the House Budget Committee's 1987 Budget Reconciliation Amendments, quality nursing home care is not without cost (H. Rept. 100-391, p. 463). The Committee anticipated then—as it does today—that a number of the reforms contained within OBRA 1987 will entail additional costs of operation for nursing facilities participating in Medicaid.

In order to assure that Medicaid State payment rates allow for these additional costs, OBRA 1987 requires that, for those Medicaid nursing facilities in compliance with the law, such rates must take into account the costs of meeting the statute's requirements relating to the provision of services, residents' rights, and administration. To ensure that State Medicaid payments actually take these costs into consideration, OBRA 1987 also requires that each State submit to the Secretary (by April 1 of each fiscal year), a State plan amendment to provide for an appropriate adjustment in payment amounts for nursing facility services furnished on or after October 1, 1990. The Secretary is required to review and approve or disapprove each such amendment by September 30 of the fiscal year concerned. The failure of the Secretary to approve an amendment, however, does not relieve either the State or any nursing facility of the obligation to comply with requirements of OBRA 1987.

The Committee bill clarifies that State Medicaid plan amendments must include a detailed description of the State methodology used in determining the appropriate adjustment in the payment amounts for nursing facility services. In addition, the bill specifies that these costs include the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(3) *Disclosure of Information of Quality Assessment and Assurance Committees.*—Under OBRA 1987, nursing facilities must establish and maintain a quality assessment and assurance committee designed to (1) identify quality assessment and assurance issues and (2) develop and implement appropriate plans of action to correct those quality deficiencies which have been identified. The Committee bill clarifies that the internal records of these committees are subject to disclosure only for the purpose of determining

whether or not such a committee is meeting its statutory obligations, and, in turn, of determining whether a nursing facility is in compliance with this OBRA 1987 requirement.

(3) *Period for Resident Assessment.*—OBRA 1987 requires that a nursing facility conduct a standardized, reproducible assessment of each resident's functional capacity which describes the resident's capability to perform daily life functions as well as any significant impairments in the resident's functional capacity. Such an assessment is to be performed no later than four days after the resident's admission. The Committee bill extends this period to 14 days.

(4) *Clarification of responsibility for services for mentally ill and mentally retarded residents.*—Under OBRA 1987, a nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. In the case of a resident with mental illness or mental retardation, however, the provision of, or the arrangement for, some of these services (such as "specialized services" as discussed in section 4431(b)(9), above) may be the responsibility or obligation of the State, not of the nursing facility.

The Committee bill simply clarifies the lines of responsibility for those residents with mental illness or mental retardation. Thus, for those treatments or services which are required by an individual with mental illness or mental retardation and which the States do not provide or arrange for (or is not required to provide or make arrangements for), the nursing facility itself must provide (or arrange for the provision of) such services.

(5) *Clarification of extent of State waiver authority.*—Under OBRA 1987, effective October 1, 1990, a nursing facility (1) must provide 24-hour licensed nursing services which are sufficient to meet the needs of its residents and (2) must use the services of a registered professional nurse for at least eight consecutive hours a day, seven days a week. A State may waive these requirements, however, with respect to a particular facility, if certain specified conditions are met.

In its February 2, 1989 final rule with comment (which became effective on October 1, 1990), HCFA set forth its explanation as to how a State may exercise this nurse staffing waiver authority. In that rule, HCFA states that a nursing facility may request a waiver from either the licensed nurse staffing requirement or the registered nurse staffing requirement (54 Fed. Reg. 5367). As the Committee understands it, this pronouncement has been interpreted to mean that a nursing facility, if it wishes to seek a waiver, must request that the entire licensed nurse staffing requirement be waived or that the entire registered nurse staffing requirement be waived; nothing less than a total waiver of either requirement, and nothing more than a total waiver of only one requirement, is to be considered.

In the Committee's view, such an interpretation is not in keeping with the intent of the OBRA 1987 nurse staffing waiver authority. As enacted, the intent of this waiver authority was to allow States to waive the nursing staffing requirements only to the extent that a facility is unable to meet them. It was never the intent of this authority to allow a State to waive completely either the licensed

nurse staffing requirement or the registered nurse staffing requirement if a nursing facility could comply with either requirement in part. Nor was it the intent of this authority to limit a State's ability to waive both requirements (or parts thereof) with respect to a particular nursing facility if the State has made a determination that the OBRA 1987 conditions for granting a waiver have been met.

In order to clarify this intent, the Committee bill modifies the nurse staffing waiver authority to provide that a State may grant a waiver of the OBRA 1987 nurse staffing requirements (both the licensed nurse staffing requirement and the registered nurse staffing requirement) to a nursing facility only to the extent that the facility is unable to meet those requirements. Thus, a nursing facility may seek a waiver from the State for all or part of either nurse staffing requirement or for all or part of both such requirements. For example, a nursing facility which is able to employ a registered nurse for eight consecutive hours a day, five days a week (but not seven), may request a waiver of the registered nurse staffing requirement for two days a week. Similarly, a nursing facility which is able to provide licensed nursing services 16 hours a day (but not 24), seven days a week, may request a waiver of the licensed nurse staffing requirement for eight hours a day, seven days a week. And a nursing facility which is able to provide licensed nursing services eight hours a day (but not 24), seven days a week, and is also able to employ a registered nurse for eight consecutive hours a day, five days a week (but not seven), may request a waiver of the licensed nurse staffing requirement for 16 hours a day, seven days a week as well as a waiver of the registered nurse staffing requirement for two days a week.

As required under the current waiver authority, however, a State may not grant any nurse staffing waiver unless the State has made a determination that the conditions specified in such authority have been met. Moreover, in granting any such waiver, a State may require a nursing facility to use other qualified, licensed personnel.

The Committee notes that the clarifications made by the Committee bill do not in any way change the requirements under current Medicaid law regarding reductions in payments to nursing facilities which have been granted a waiver of the OBRA '87 nurse staffing requirements. Under Section 1902(a)(13)(A), Federal Medicaid payments to any nursing facility that has received such a waiver must be reduced (relative to payments made to a comparable nursing facility that is in compliance with the nurse staffing requirements) to take into account the waived facility's lower costs. Thus, Federal Medicaid payments to any nursing facility which operates under any nurse staffing waiver are to be decreased to the extent the waiver results in a reduction of the costs of such a facility.

(6) *Clarification of definition of "nurse aide."*—OBRA 1987 specifies those individuals who are subject to the nurse aid training and competency evaluation requirements to include any individual who provides nursing or nursing-related services to residents in a nursing facility. The Committee bill clarifies that such individuals do not include registered dietitians.

(7) *Clarification of requirements for social services.*—Under OBRA 1987, a nursing facility with more than 120 beds is required to have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide (or to assure the provision of) social services to the residents of the facility. The Committee bill modifies this requirement to allow such a facility to employ instead (on a full-time basis) at least one individual who is provided with on-going consultation and assistance in providing social services by a social worker who has at least a bachelor's degree in social work or similar professional qualifications.

(8) *Charges applicable in cases of certain medicaid-eligible individuals.*—Under current law, providers participating in Medicaid, including nursing facilities, must accept payment made by the State on behalf of eligible beneficiaries as payment in full. The only exception to this is that providers may collect nominal cost-sharing obligations which the State is allowed to impose on certain classes of beneficiaries; however, eligible residents in nursing facilities who are required to apply most of this income to the cost of care are not subject to cost-sharing. The purpose of this mandatory assignment requirement is to protect low-income individuals from excess provider charges.

There are circumstances in which, under current law, a State may not actually be making payments to a nursing home on behalf of a resident who is eligible for Medicaid. For example, a nursing home resident may be receiving Veterans' Administration aid and attendance payments. In a State which covers institutionalized individuals with incomes below 300 percent of the SSI benefits level, these payments are not taken into account in determining initial eligibility for Medicaid. However, these payments are considered in determining post-eligibility, the amount of an individual's monthly income that is available to be applied to the cost of care.

Assume a State which sets its 300 percent eligibility threshold at \$1,104 per month and which pays for nursing facility care at \$1,165 per month (an intermediate care facility or "ICF" rate of \$38.83 per day). If a resident has a monthly income of \$2,250, of which \$150 is Veterans' aid and attendance benefits, then the resident will be eligible for Medicaid (\$1,100 is lower than the \$1,104 income threshold), but the State will not actually make any payment (\$1,250, less a \$30 personal needs allowance, leaves \$1,220, which exceeds the cost of care to the State of \$1,165). It is the understanding of the Committee that, in such circumstances, nursing facilities have charged these residents at "private pay" rates which are significantly higher than the Medicaid payment levels, even though these residents are Medicaid eligible.

The Committee bill clarifies that, in such cases, nursing facilities may not charge more than the rate which the State has established under its Medicaid plan. The Committee bill prohibits a nursing facility participating in Medicare from imposing charges for Medicaid-eligible individuals for covered services that exceed the payment amounts established by the State for those services. This prohibition specifically applies in situations where the State is not making any payment to a nursing facility on behalf of a Medicaid-eligible resident because the individual's post-eligibility income ex-

ceeds the payment amounts established under the State Medicaid plan.

(9) *Residents' rights to refuse intra-facility transfers to move the resident to a medicare-qualified portion.*—Under current law, a resident can be transferred or discharged within a nursing facility “. . . only for medical reasons or for his welfare or that of other patients or for non-payment of his stay . . . and [only if he is] given reasonable advance notice to ensure orderly transfer or discharge and such actions are documented in his medical record” (42 C.F.R. 405.1121(k)(4)). Under this rule, the involuntary transfer of “dually-eligible residents” (individuals who are eligible for both Medicare and Medicaid) for the sole purpose of taking advantage of a higher reimbursement rate that is most often paid for the Medicare skilled nursing facility (SNF) benefit is clearly prohibited. Nonetheless, in response to the expanded Medicare SNF benefit that was established (and later repealed) under the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), a number of nursing facilities were reported to have involuntarily transferred or relocated their dually-eligible residents from their Medicaid-certified beds to their Medicare-certified beds for just this purpose. Such transfers led to confusion, depression, and loneliness among the residents affected.

At the time of these reports, HCFA contacted all nursing home administrators whose facilities are certified under either Medicare or Medicaid, or under both programs to reiterate its position on the transfer of nursing facility residents. In its June 12, 1989 letter to these administrators, HCFA stated:

It is clear that an individual cannot be moved except for medical reasons or non-payment. With respect to non-payment under Medicare or Medicaid, you should be aware that an individual cannot simply be moved from either a Medicare bed or from a Medicaid bed because the individual is no longer eligible for the benefit unless you provide them proper notification of their rights under the applicable statute.

Furthermore, a person cannot be required to move from his/her bed into a Medicare certified bed simply to take advantage of the Medicare benefit. Although Medicaid is required under certain circumstances to seek payment for services from other parties, it is not required to mandate transfer of an individual from one place to another to obtain these payments.

HCFA went on in its letter to acknowledge—as this Committee does now—the reimbursement dilemma that came about in response to the 1988 expanded Medicare SNF benefit: a resident must occupy a Medicare-certified bed in order for a facility to receive Medicare payment, but in order to occupy such a bed, a resident may have to be moved, in violation of current law. To avoid this potential conflict in the future, HCFA suggested in its letter that nursing facilities consider having all of their beds “dually-certified” at the SNF level. The Committee concurs in this view and emphasizes that such action is particularly appropriate now since, effective October 1, 1990, there is no longer a distinction between the two different types of Medicaid-certified beds. In the intervening time, however, the Committee expects the Secretary to continue to enforce current law regarding residents' transfer rights as specified in 42 C.F.R. 405.1121(k)(4), quoted above.

Nonetheless, to ensure that these rights are protected under OBRA 1987, the Committee bill establishes the right of a resident to refuse a transfer to another room within the facility if a purpose of the transfer is to relocate the resident from a non-Medicare-certified portion of the facility to a Medicare-certified portion of the facility. The Committee stresses that the relocation of a resident to a Medicare-certified portion of the facility need not be the sole purpose for the transfer to trigger the resident's right; the relocation for the higher Medicare payment need only be one of the reasons for the move.

If a resident refuses such a transfer, the Committee bill further provides that neither the resident's eligibility for Medicaid nor the State's entitlement to Medicaid Federal matching payments is affected. Thus, a resident who refuses such a transfer may, under the Committee's bill, remain in his or her current bed location and continue to be eligible for Medicaid services. If that bed is (or ever becomes) Medicare-certified or "dually-certified," however, the nursing facility would be able to receive the Medicare reimbursement rate for the services provided.

(10) *Residents' rights regarding advance directives.*—OBRA '87 established a number of "residents' rights" that nursing facilities must meet in order to be in compliance with the requirements of that law. The Committee bill adds to this list of rights, the right to compliance by a nursing facility with the provisions of an advance directive (such as a living will or a durable power of attorney for health care) that a resident has executed in accordance with State law.

(11) *Resident access to clinical records.*—OBRA 1987 established a number of "residents' rights" that nursing facilities must meet in order to be in compliance with the requirements of that law. Among these is the right to confidentiality of personal and clinical records. The Committee bill adds to this provision the right of residents to have prompt access, upon request, to their current clinical records. Such a request need not be in writing.

(12) *Inclusion of State notice of rights in facility notice of rights.*—Among the "residents' rights" established under OBRA '87 is the right that nursing facilities make available to each resident, upon reasonable request, a written statement of the resident's legal rights during his or her stay at the facility and of the requirements and procedures for establishing Medicaid eligibility. The Committee bill adds to this provision a requirement that a nursing facility's statement include any written notice, prepared by the State under the requirements of OBRA '87, of the rights and obligations of residents (and their spouses) under the Medicaid program.

(13) *Removal of duplicative requirement for qualifications of nursing facility administrators.*—Current Medicaid law provides that a State Medicare plan must include a program which meets specified requirements for the licensing of nursing facility administrators. Under OBRA '87, however, nursing facility administrators are not required to be licensed; instead, they are required to meet standards set by the Secretary. The Committee bill therefore repeals, effective October 1, 1990, the current Medicaid provisions relating to nursing facility administrators.

(14) *Clarification of nurse aide registry requirements.*—Under OBRA '87, effective January 1, 1989, States must establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a competency evaluation program, approved by the State. The Committee bill clarifies that such individuals include those who have been "deemed" to have met the OBRA '87 nurse aide training and competency evaluation requirements.

In addition, the Committee bill specifically prohibits a State from imposing any charges on nurse aides relating to the State's nurse aide registry. It is the Committee's understanding that some States are currently imposing registration fees on nurse aides whose names are required to be listed in the States' nurse aid registry. Such fees (or any other type of charges) were never intended to be placed on nurse aides as part of the OBRA '87 nurse aide registry requirements. The Committee bill specifies that such practices are not permitted.

(15) *Clarification on findings of neglect.*—Under OBRA '87, States are required (through their agencies responsible for surveys and certifications of nursing facilities) to review, investigate, and make findings with respect to allegations of neglect or abuse of a resident, or of misappropriation of a resident's property, which are brought against a nurse aide or other individual used by a nursing facility to provide services to such a resident. States are also required to notify the appropriate State authority if a nurse aide or other individual is found to have neglected or abused a resident or to have misappropriated resident property in a nursing facility.

Under the Committee bill, however, a State is prohibited from making a finding that an individual has neglected a resident if the individual can demonstrate that such neglect was caused by factors beyond his or her control. Thus, under this standard, a nurse aide (or other individuals used to provide services to residents) cannot be found to have "neglected" a resident if, for example, he or she can demonstrate that the reason a meal went undelivered was because no food was available rather than because of an unwillingness to deliver the meal. Similarly, a nurse aide cannot be found to have "neglected" a resident if he or she can demonstrate that, at the time a resident needed to be turned in bed, he or she was required to provide, because of a shortage of personnel, more urgent health-related services to other residents.

In the Committee's view, nurse aides and other individuals who provide nursing facility services to resident should not be used as "scapegoats" for those who may have either the responsibility or capability of preventing or correcting the deficiencies that have resulted in a charge of resident neglect. Thus, the purpose of this standard is to help ensure that such individuals are not held responsible for actions and activities (such as a shortage of staff, or a shortage of supplies such as dressings, linens, and food) which they can demonstrate are beyond their control.

(16) *Timing of public disclosure of survey results.*—Under OBRA '87 each State and the Secretary must make available to the public, information relating to all surveys and certifications, including statements of deficiencies and plans of correction respecting all nursing facilities. The Committee's bill specifies that, with

respect to information concerning surveys, certifications, and statements of deficiencies, such information must be made available to the public within 14 calendar days of the time it is made available to the nursing facilities that have been surveyed. In addition, the Committee bill specifies that only approved plans of correction must be made available to the public.

(17) *Denial of payment of legal fees for frivolous litigation.*—Under current Medicaid law, Federal payments are not to be made to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under the OBRA '87 enforcement process. The Committee bill also prohibits Federal Medicaid payments from being made to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of the action.

(18) *Effective dates.*—The Committee bill provides that, except for the provisions relating to Sections 4431(e)(8) and 4431(e)(13), all of the additional amendments made to the OBRA '87 requirements are to take effect as if they were included in the enactment of OBRA '87. With respect to the amendments made under Section 4431(e)(8) (relating to charges applicable in cases of certain Medicaid-eligible individuals), the bill provides that they are to take effect on the date of the enactment of this Act, without regard to whether or not regulations to implement such amendments have been promulgated by the Secretary. With respect to the amendments made under Section 4431(e)(13) (relating to removal of duplicative requirement for qualifications of nursing facility administrators), the bill provides that they are to take effect October 1, 1990.

PART 5—MISCELLANEOUS PROVISIONS

Subpart A—Payments

and

Subpart B—Eligibility and Coverage

Section 4441—Section 4458

Subpart C—Health Maintenance Organizations

Section 4461—Section 4465

Subpart D—Demonstration Projects and Home and Community-Based Waivers

Section 4471—Medicaid long-term care insurance demonstration projects

Current law

Under current law, long-term care is the single largest Medicaid benefit. Over 28 percent of all Medicaid expenditures—an estimated \$15.5 billion in Federal funds in FY 1990—pays for nursing facility, personal care, home health, or home and community-based services. In order to qualify for these long-term care benefits, indi-

viduals must meet the Medicaid income and assets tests. These vary from State to State and category to category, but all require that beneficiaries effectively impoverish themselves. For example, in Connecticut elderly individuals living in the community may not qualify for Medicaid unless their monthly income is less than \$538, or 102 percent of the Federal poverty level, and their liquid assets are less than \$2000. Elderly nursing home residents may qualify for Medicaid in Connecticut with incomes as high as \$1104 per month, or 211 percent of the poverty level, and with liquid assets not exceeding \$2000. Efforts to transfer resources for less than fair market value in order to qualify for Medicaid coverage may result in a denial of eligibility.

Once institutionalized, a single individual who has established Medicaid eligibility must generally apply all of his or her Social Security and pension income, other than a \$30 personal needs allowance, toward the cost of nursing home care. (Nursing facility residents with spouses in the community may apply more of their income toward the maintenance of the spouse in order to avoid "spousal impoverishment.") If the institutionalized beneficiary's assets increase to the point that they exceed \$2000, the individual loses Medicaid coverage until the assets are again reduced below the eligibility threshold.

As stringent as these income and assets requirements may seem, they are considerably more generous than those which apply to families with children. For example, in determining Medicaid eligibility for non-pregnant women and children over age 5 living in the community, Connecticut uses an income standard of \$649 per month for a family of three, or 74 percent of poverty, and a liquid resource limit of \$1,000.

Committee action

On September 10 and 14, 1990, as part of a hearing on Medicaid provisions related to budget reconciliation for the fiscal year 1990, the Subcommittee took testimony from proponents and critics of H.R. 2499, the Medicaid Long-term Care Demonstration Waiver Act of 1989. Among those supplying the Committee with testimony were Representative Barbara Kennelly, the sponsor of H.R. 2499, Families USA, and the General Accounting Office which supplied the Subcommittee with its September 1990 report "Long-term care Insurance, Proposals to Link Private Insurance and Medicaid Need Close Scrutiny."

In addition, during a 12 month period over 1989 and 1990, the Subcommittee on Oversight and Investigations conducted an in-depth investigation into the sales, marketing and regulation of long-term care insurance. The Subcommittee issued its findings of widespread abuse and lack of effective regulation in reports and in testimony presented at a Subcommittee hearing on May 2, 1990. (No. 101-146) Among those testifying were representatives on the long-term care insurance industry who supported the need for effective federal regulation prior to granting any federal waivers for demonstration projects for public reinsurance of private long-term care insurance.

Purpose and summary

This provision authorizes the Secretary to approve demonstration projects designed to assist certain individuals in protecting assets by making individuals 65 years or older who have exhausted benefits under certain long-term care insurance policies eligible to receive long-term care services under Medicaid. The provision is a federal response to a group of projects sponsored by the Robert Wood Johnson foundation in conjunction with a number of states to explore the potential benefits and costs of publicly reinsuring private long-term care insurance.

Subsection (a) authorization of projects

This Subsection establishes the basic authority for the Secretary to approve such projects as demonstrations.

(1) Authorizes the Secretary to approve such projects and qualifies state expenditures for approved benefits as medical assistance for the purpose of obtaining for federal financial participation.

(2) Requires (for purposes of eligibility) that States with qualifying projects disregard the income of covered beneficiaries who are 65 years or older and who have exhausted benefits under a qualified insurance policy and reduce the valuation of assets for such individuals by the lesser of \$75,000 indexed to inflation or the amount of protection purchased by a qualified long-term care policy (QLP). (The reduction in the valuation of assets is limited as described so that qualified beneficiaries under the project would otherwise be required to contribute the same amount toward covered long-term care services as other beneficiaries.) Further States are otherwise prohibited from discriminating between beneficiaries qualifying for coverage under a project and other beneficiaries.

(3) Defines terms including "qualified long-term beneficiary" (QLB) as an individual purchasing benefits under a qualified long-term care insurance policy; "long-term care services" as otherwise covered state plan benefits for nursing facility services, home health care services, private duty nursing, case management services, homemaker/home aide services, personal care services, adult day health services and respite care; and "qualified long-term care insurance policy" (QLP) as a plan meeting certain requirements specified in subsection (e) below.

Subsection (b) Terms of Projects

This subsection establishes the term which must be met for the Secretary to consider approval of a project.

(1) The Secretary must find that the terms of a project are to be disclosed to each individual before such individual is enrolled in the project and that the QLP in no way limits payment under the policy because the beneficiary is eligible for a public program.

(2) In no case may the Secretary approve projects resulting in a total of more than 25,000 covered long-term care beneficiaries; but the Secretary may require a project to permit enrollment of a minimum number of covered beneficiaries.

The Committee is concerned that the projects sponsored by the Robert Wood Johnson foundation would represent a dramatic departure from the traditional function of Medicaid, a program de-

signed to cover the health and long-term care needs of the nation's poorest citizens. Further, it departs equally dramatically from the function of demonstration project—that of demonstrating a desired policy objective in a finite period of time. The project raises profound policy questions about public private partnerships, entitlement programs, long-term care policy, and insurance regulation. (The Committee is concerned that the number of variables in this experiment is so high, that controlling for them is quite difficult. This is one reason why the Committee has sought to define with some precision the parameters of the projects.) Finally, the lessons and implications of this experiment may not be demonstrated until well into the next century. For these reasons, the Committee bill would limit the number of participants. However, the Secretary is given the discretion to determine the number of approved projects. The Committee would intend, however, that the Secretary give consideration to the statistical and practical implications of its determinations with respect to the number of approved projects.

(3) Under this paragraph, the Secretary is permitted to waive certain requirements of Title XIX for covered long-term care beneficiaries 65 or older who have exhausted benefits under a QLP. In particular, the Secretary may waive certain provisions relating to required eligibility and benefits and premiums and cost sharing. The provision permits but does not require the Secretary to waive such provisions and expressly limits any waiver to the extent that it is required to carry out a project.

Subsection (c) Limitation on Payment

This subsection places limits on federal financial participation for the projects.

The subsection expressly limits federal financial participation for any year in which the project is in effect (i.e. any year in which covered beneficiaries could receive benefits under Title XIX) by prohibiting such payments which exceed the projected amount (determined by the Secretary at the time of approval of the project) that the State would have spent on long-term care services under its state Medicaid plan for individuals 65 years or older had this section not been in effect.

The Committee has received repeated assurances from architects of the Robert Wood Johnson projects that such projects will, at a minimum, be "cost neutral" for the Medicaid program, and more likely, will achieve savings for the program. This provision simply codifies those assurances. The Committee considers strict implementation of this provision to be essential to the initiation and success of the provision. Only if the Secretary can first confidently develop a measure of cost neutrality can a project be approved and two important objectives be met: that of proving the cost-effectiveness of such projects and that of protecting the fiscal integrity of the nation's only major health program for the poor.

Subsection (d) State Assurance

This subsection enumerates the assurances that a State must provide to the Secretary's satisfaction before approval of a State application may be considered.

(1) This paragraph establishes a standard of budget neutrality by requiring that qualifying States demonstrate that aggregate expenditures under the plan for long-term care services for individuals 65 or older will not, for any fiscal year, in which the project is in effect exceed the aggregate such expenditures in the absence of such project.

This provision protects both participating States and the Federal Government from having to apply the potentially adverse consequences of subsection (c) above by requiring a finding of cost neutrality prior to the approval of any project. The Committee intends that the same requirement, that the Secretary have adequate means for assessing such submissions (described above) apply.

(2) This paragraph protects actual and potential Medicaid beneficiaries from potentially adverse effects of the projects by prohibiting reductions or limitations of benefits to any individual eligible for medical assistance under the State Medicaid plan which result from the operation of the project.

(3) This paragraph further protects beneficiaries by requiring the State to continue making long-term care services available under its plan, at least to the extent such services are in effect before the date of approval.

(4) This paragraph protects covered beneficiaries by requiring the State to forbid the sale of substandard policies under the project. Accordingly, policies must meet certain standards enumerated below, as well as standards at least as stringent as those in the current National Association of Insurance Commissioners (NAIC) Model Act and Regulation to the extent not inconsistent with the enumerated standards.

(5) This paragraph assures that States protect individuals purchasing policies in their States from confusion resulting from the sale of policies which do not meet the requirements of the project by requiring disclosure to such individuals that such purchases will not provide any potential benefits under title XIX.

(6) This paragraph protects covered beneficiaries from insurers unable or unwilling to honor obligations under long-term insurance policies covered by the project by requiring that the State assure the Secretary that it will guarantee payment of benefits under such policies. The subsection denies Federal financial participation for commitments required by such guarantees. The Committee seeks to protect the interests of policyholders but because of concern that scarce Federal Medicaid resources could be used for such purposes, the provision provides incentives to States to prevent the need for guarantee payments by adequately regulating insurers, particularly with regard to solvency.

(7) This paragraph assures that State participation in a project will not undermine or deter State efforts to meet the needs of the most vulnerable of their poor citizens, pregnant women and infants. It requires that States fully exercise the Federal option to cover such individuals with incomes up to 185 percent of the poverty line under their State plans.

(8) This paragraph protects covered beneficiaries needing nursing facility services by requiring the State to be in compliance with Medicaid requirements assuring the quality of care provided in such facilities.

(9) This paragraph prevents the incidental or deliberate use of a project to continue or initiate discriminatory treatment of Medicaid eligible individuals by requiring the State to require that nursing facilities under the Medicaid plan establish and maintain identical policies and practices regarding admission for all individuals whether or not the individuals participate in the project.

(10) This paragraph assures that the stability and reliability of long-term care insurance policies sold under the project by requiring States to have in place actuarial guidelines and actuaries capable of evaluating the submissions of companies seeking to qualify long-term care policies under the project.

The Committee is deeply concerned about evidence it has received that development and State approval of widespread sales of a variety of long-term care policies are occurring without necessary actuarial principles in place or trained personnel capable of applying such principles. This paragraph is designed to assure that an adequate basis for properly assessing and comparing the solvency, loss ratio submissions, pricing and other actuarial assumptions of individual insurers are established and enforced.

(11) This paragraph assures that State residents be given an opportunity to fairly evaluate the relative costs, benefits and appropriateness of participating in the project by requiring States have in place a counseling program to help residents assess such factors.

The Committee is concerned about the lack of good information that has been developed and disseminated to advise potential consumers of long-term care of the appropriateness of particular purchases. This concern is greatly magnified when both State and Federal dollars are committed to effectively reinsuring private insurance. Accordingly, the Committee intends that participating States demonstrate to the satisfaction of the Secretary that accurate and useful information be developed and disseminated through a counseling program. Long-term care insurers and consumer representatives have advised the Committee that such insurance is often not an appropriate investment for many income groups and ages. The Committee intends that one purpose of counseling be the evaluation of such factors. Other purposes are the comparison of the costs and benefits of not purchasing coverage, of using alternative financial instruments for protecting financial security and insuring joint catastrophic costs and comparisons of various policies.

(e) Requirements for qualified long-term care insurance

This subsection establishes requirements for QLPs to assure that the demonstration projects both protect QLBs from substandard coverage and yield information useful for designing public policy concerning the joint public private coverage of long-term care services.

(1) To foster competition and reduce confusion, this paragraph requires QLPs and associated marketing material to be written in simple English and in a standard format. Disclosure of loss ratios and the potential benefits with regard to entitlements under title XIX associated with purchase of the QLPs must also be disclosed. The Committee intends that all such disclosures with regard to title XIX benefits accurately state the precise boundaries and limitations of such benefits with and without purchase of a QLP.

(2) To assure that policies return a fair proportion of premiums collected, this paragraph requires that each QLP guarantee, under generally accepted actuarial principles, a loss of ratio of at least 70 percent. The Committee is concerned about the absence at present of such actuarial principles and believes that they are essential to the fair evaluation of such products and protection of consumers. Accordingly, the provision assumes development of such principles prior to the issuance of QLPs.

(3) To assure that policies contain benefits representing at least minimum needs of consumers, this paragraph requires that QLPs provide certain nursing facility and home- and community-based services. Further no durational limits on policies may be imposed beyond those resulting from maximum dollar coverages and such limitations shall be applied uniformly among types of coverages. Therefore, if a limit of \$50,000 worth of coverage were purchased, the insurer would have to provide coverage for up to \$50,000 of each type of covered service, provided however, that the insurer would be liable for no further payments upon exhaustion of the first \$50,000 (adjusted for inflation) of payments irrespective of the distribution of such payments by service. Finally, while insurers would be free to establish initial payment levels for particular services, such levels would be required to be adjusted annually for inflation. In the absence of such protection from inflation, benefits derived from policies purchased many years prior to benefit payment could be illusory.

(4) This paragraph requires that each QLP specify a maximum dollar level of benefits which would be required to be indexed annually to inflation. (As noted above, QLPs could not in any event qualify for a reduction in their valuation of assets under the project of an amount greater than the lesser of \$75,000 indexed for inflation and the maximum benefit level of the QLP.)

(5) To assure uniform and reliable determinations of benefit eligibility, this paragraph requires QLPs to use a standard formula established by the State and based on a uniform assessment instrument established by the State, to determine the level of care appropriate for individuals eligible for benefits under QLPs and to determine the appropriateness of benefit payments under such QLPs. To assure that no conflicts of interest arise with respect to payment of benefits and that QLPs may fairly compete without concern that certain insurers may rely on overly restrictive or biased benefit determinations, the formula would have to be applied by the State or an independent case-management agency. Use of case-management should help assure proper utilization of services and reduce costs.

To protect against arbitrary denials of benefits and illusory benefits, conditioning or limiting eligibility for care on receipt of other services or medical necessity for such benefits is prohibited. To assure that beneficiaries are further protected from these practices, certain appeal procedures are established.

(6) To protect potential purchasers of QLPs against application of medical underwriting standards that could restrict participation to an overly narrow group of individuals and limit the value of the demonstration project to show the ability of private long-term care insurance to insure broad sections of the population, this para-

graph limits pre-existing condition exclusions to a six-month period.

(7) To protect potential purchasers of QLPs against the practice of post-claims underwriting and unwarranted rescissions and cancellations, this paragraph restricts denials of claims to instances in which timely payments of premiums have not been made.

(8) This paragraph includes a number of requirements related to the pricing of QLPs.

(A) This subparagraph prohibits discrimination in the purchase, renewal or provision of benefits based on an individual's medical condition. Exceptions are provided in cases in which individuals are receiving long-term care benefits at the time of application for issuance. Further, the provision does not prohibit insurers from establishing separate pricing structures based on the age of the applicant at the time of issuance.

The Committee is extremely concerned about the deterioration of community rating in the private health insurance market and the proliferation of medical underwriting. The Committee is not anxious to sanction the replication of that experience with respect to long-term care insurance. Accordingly, a strong medical underwriting restriction is included. It is designed to insure that the projects be used to demonstrate the potential effectiveness of a public private partnership where the private program is subject to at least some of the same requirements faced by a public program. The Committee sees little value in sanctioning a demonstration project involving private insurance to show that only public programs can meet the needs of a cross section of citizens. The Committee is anxious to learn the boundaries of what private insurers can do in this respect and believes that such learning will only occur if private insurers are required to adhere to certain requirements, including restrictions on underwriting. To counteract the problem of adverse selection, the provision does provide for a waiting period and permits denial of sale to individuals receiving benefits at the time of application.

Second, the Committee is concerned about a basic issue of fairness raised by medical underwriting. Medical underwriting is a practice that discriminates—often arbitrarily—against certain individuals who may be in greatest need of the services for which insurance is provided. Finally, with advances in medical and genetic testing, the practice of medical underwriting poses deep ethical concerns. Without strict limits, medical underwriting has boundless potential as a tool for economic, racial and sex discrimination that could prejudice individuals and groups from the earliest age.

(B) This subparagraph requires sellers of QLPs to establish periodic premiums which are guaranteed for the duration of the policy and which are the same for all individuals in the same age group at time of purchase. Further, premium payments must be suspended during any period in which benefits are payable under the policy.

Inasmuch as the benefits offered under QLPs are limited by dollar amount, insurers should be able to determine the potential payout and spread the cost over the likely period of coverage. Obviously assumptions about utilization are also required; however, entry into the market by an insurer without such information

would raise questions about the basis for the insurers pricing and loss ratio assumptions and call into question its ability to limit the risk it has assumed.

Under the requirements of the provision, and according to insurance principles, the insurer—rather than the insured—assumes the risk for any miscalculations or unpredictable events. Further, in the absence of a guaranteed rate structure, it becomes virtually impossible for a potential policyholder to assess the relative value of purchasing insurance. For instance, if a premium could (without warning) rise to a large percentage of the amount insured event, it would lose its characteristic as insurance and become an unwise use of resources. Finally, the provision removes confusion about the meaning of level premiums and effectively prohibits misleading statements about the lack of potential increases in premiums. The Committee has received strong evidence from actuaries and consumers that such matters pose grave actual and potential dangers for policyholders.

(C) In order to reduce payments for duplicative coverage, but subject to the secondary payor provisions of the Medicare program, QLPs are required to offer benefits which do not duplicate covered benefits under Medicare.

(D) Under this subparagraph each QLP must vest policy-holders with certain rights to benefits after five years of coverage. Specifically, the provision provides that in the event of a lapse in coverage after five years, policy-holders would be entitled to coverage of at least 30% of the maximum dollar level of benefits available at term, i.e. an amount reflecting the maximum dollar level purchased adjusted, as required, for inflation. For periods of coverage in excess of 5 years, the 30% figure would be increased proportionately according to a schedule established by the Secretary.

The Committee is concerned about evidence that it has received that many long-term care insurance policies have extremely high lapse rates with the result that many policy-holders derive extremely limited opportunities for meaningful protection from such coverage. This provision seeks to balance the interest of controlling premium costs with the protection of potential purchasers who, for any of a variety of reasons, may not continue coverage.

(E) This subparagraph requires each QLP to meet a number of essential consumer protection amendments recently made part of the NAIC Model Regulation for Medigap insurance. The provisions would protect consumers against a variety of untoward sales and marketing practices and apply affirmative obligations on sellers to assure the appropriateness of the sale of such products. The Committee has been advised by consumer representatives and regulators that the same abusive practices that have plagued the Medigap market are afflicting the long-term care insurance market and that the potential for abuse is even greater. The Committee is anxious to prevent these practices.

(9) This paragraph requires issuers of QLPs to make available to the State and the Secretary, upon request, information regarding administration of and utilization under such policies, and such other information as the Secretary may require. A broad grant of Secretarial access to information from issuers of QLPs is granted to permit the Secretary to adequately assess the policy implications of

projects, including comparisons of data concerning QLPs and other long-term policies sold by insurers. Further, such a grant is required to permit the Secretary to enforce the substantive requirements contained other subsections of the provision. Finally, the grant to both the state and Secretary is consistent with the objective of the Robert Wood Johnson foundation to develop meaningful information to assess the potential of private long-term care insurance in meeting the needs of the broadest number of individuals for long-term care services.

(f) Prohibited sales practices

This subsection imposes certain obligations on issuers with respect to the sale or offer for sale of QLPs.

(1) A duty of good faith and fair dealing is imposed on those selling or offering for sale a long-term care insurance policy. This provision codifies this affirmative duty on insurers and agents in order to protect purchasers and potential purchasers from acts of bad faith and to give statutory meaning to assurances from insurers and agents that they are governed by principles of fair dealing in the sale and offering of such policies. The Committee does not intend to diminish any state requirement establishing such an obligation.

(2) A specific prohibition is included against the seller or offeror of a policy completing the medical history portion of an application. The Committee has received ample evidence that without such a prohibition completion by an agent or other representative of an insurer can be the precursor for the abusive practice of post claims underwriting.

Additionally, knowingly selling or offering for sale a policy for a Medicaid eligible individual is prohibited. This provision is required because poor individuals eligible for assistance under that program would gain little if any benefit from such purchase.

Finally, the subsection prohibits knowingly selling a QLP which duplicates coverage to which an individual is otherwise entitled and sales which occur without the seller or offeror first obtaining a statement that the coverage does not duplicate other coverage which is in effect.

(3) The Subsection and the requirements of subsection (e) are enforced with civil money penalties for each violation.

(g) Application, duration, and eligibility

This Subsection gives the Secretary 90 days from the time of submission of an application by a state to deny such application or request further information. In the event, the Secretary requests further information, the application is deemed granted if the Secretary does not deny it within 90 days of receipt of the information requested.

The Subsection clarifies that any termination of a previously approved application shall not affect covered long-term care beneficiaries who purchased QLPs before the termination date.

Subsection (h) Annual State Reports

This Subsection requires states with approved projects to annually submit to the Secretary reports with regard to the characteristics of enrollees and participating insurers.

Subsection (i) Secretary's Reports

This Subsection requires the Secretary to submit periodic reports to the Congress summarizing and analyzing the state report information in Subsection (h) and evaluating the cost effectiveness of the projects. The Committee notes that the last of these reports is due in the year 2021, approximately 30 years from the commencement of the project. The Committee regrets that the nature of this project is such that meaningful information permitting assessment of the projects will not in some instances be available until at least two decades have passed. The Committee expects that the Secretary will make known to the Congress any important conclusions or recommendations reached in intervening years and before any prior reports are due.

Section 4472—Section 4474

Subpart E—Miscellaneous

Section 4481—Medicaid State plans assuring the implementation of a patient's right to participate in and direct health care decisions affecting the patient

In July 1990, the U.S. Supreme Court issued its opinion on *Cruzan v. Director, Missouri Department of Health* 110 S.C. 2841 (1990), a case in which the Court recognized a patient's right to die and endorsed the withdrawal of life support and the withholding of medical treatment in cases where a patient's wishes were known. The Court's decision provided, however, that such actions could only be carried out in situations where the patient's wishes had been made clear.

The Supreme Court's decision has served to highlight the importance and usefulness of "advance directives" such as living wills and durable powers of attorney. These instruments—which are recognized in law by almost all States—are intended to establish an individual's preferences with respect to medical care and treatment and to help ensure that those preferences are respected. They are designed to document how an individual would like to be treated or who should make treatment decisions, if the individual should become incapacitated and lose the ability to communicate. They are, indeed, meant to serve as the documentation or proof that the Supreme Court was looking in the *Cruzan* case.

Most Americans are not aware, however, of their right to refuse medical treatment or of their right to execute an advance directive. In light of the *Cruzan* decision, it is the Committee's view that such information should be made available to adult Americans so that they can best be prepared to exercise those rights. Section 4481 is designed to help meet that objective.

(a) *In General.*—Subsection (a) of Section 4481 requires that, as a condition of participation in Medicaid, each hospital, nursing facility, provider of home health care or personal care services, hospice

program, or health maintenance organization, must maintain written policies and procedures regarding the receipt of medical care by adult individuals from or through each such provider. Such policies and procedures are to include a process for providing written information to each such individual on (1) the individual's rights under State law to make decisions concerning the individual's medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and (2) the provider's written policies respecting the implementation of these rights. Such policies and procedures must also provide for documentation (in the individual's medical record) of whether or not the individual has executed an advance directive as well as for assurances of the provider's compliance with the requirements of State law respecting advance directives. In addition, such policies and procedures must specify that the provision of care by the provider is not conditioned on whether or not the individual has executed an advance directive. Finally, these policies and procedures must provide for the education of staff and the community on issues concerning advance directives.

The Committee notes that primary purpose of these provisions is to ensure that adult individuals have the information they need in order to protect their legal rights to make decisions about their medical care and to execute appropriate documentation for the enforcement of those decisions. No individual seeking services from a Medicaid provider is required to execute a living will or a durable power of attorney. And no such provider is required to assist any individual in formulating an advance directive. All that is required is that adult individuals be provided with information concerning applicable State law and that Medicaid providers establish policies and procedures to ensure compliance with that law.

(b) *Conforming amendments.*—Subsection (b) of Section 4481 makes conforming amendments to appropriate sections of the Medicaid statute.

(c) *Effective date.*—Subsection (c) of Section 4481 provides that the provisions of Section 4481 shall apply with respect to services furnished on or after the first day of the first month beginning more than one year after the date of enactment.

(d) *Study to assess implementation of a patient's right to participate in the direct health care decisions affecting the patient.*—Subsection (d) of Section 4481 requires the Secretary to contract with the Institute of Medicine of the National Academy of Sciences to conduct a study with respect to the context in which directed health care decisions (including advance directives) are made and carried out. Such study is to include recommendations for any appropriate Federal legislation. The results of the study are to be reported to the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, and to the Committee on Finance of the Senate not later than four years of the date of enactment.

(e) *Public education demonstration project.*—Subsection (e) of Section 4481 requires the Secretary to develop and implement a demonstration project to inform the public about their rights (1) to participate in and make decisions about, their medical care and treatment and (2) to execute advance directives. The results of this dem-

onstration project are to be reported to the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, and to the Committee on Finance of the Senate.

Section 4482—Section 4485

Subtitle C—Energy and Miscellaneous Users Fees

PART 1—ENERGY

SEC. 4501. SOLAR, WIND, WASTE, AND GEOTHERMAL POWER PRODUCTION.

Section 4501 removes the size limitations on solar, wind, waste, and geothermal small power production facilities under the Public Utility Regulatory Policies Act of 1978 (PURPA). At present, those limitations stand at either 30 or 80 megawatts (depending on the technology); the Federal Energy Regulatory Commission (FERC) has no authority to raise those limits under current law.

BACKGROUND AND NEED FOR LEGISLATION

The Public Utility Regulatory Policies Act of 1978 (PURPA) provides certain types of powerplants, known as "qualifying facilities" (QFs), two types of benefits.

To qualify as a QF, a powerplant has to meet certain restrictions based on ownership, type of plant, and size. QFs cannot be more than 50 percent owned by a public utility. They must either be a cogeneration plant or be powered by renewable resources, geothermal, biomass, or waste. Finally, they have to be under certain size limitations, explained in more detail below, to qualify for the benefits conferred by PURPA.

The first type of benefit is a guarantee that the local utility will purchase their power and interconnect them to the local grid. The purchase price, however, is not guaranteed.

The second type of benefit is an exemption from regulation as a utility under Federal and state law. More specifically, QFs are not regulated as electric utilities under most provisions of the Federal Power Act, the Public Utility Holding Company Act of 1935, and state law regarding rate setting and other utility regulations. By contrast, such QFs may (depending upon their size and/or technology) be subject to Clean Air Act and other environmental law and regulation.

Currently, cogeneration QFs may be of any size to qualify for both types of benefits. Geothermal QFs must be 80 MW or smaller to qualify for both types of benefits. Renewable resource and waste QFs must be 80 MW or smaller to qualify for the mandatory purchase and interconnection benefits but cannot exceed 30 MW if they want to qualify for the regulatory exemptions.

The purpose of these parts of PURPA was to encourage the development of electric power sources that relied on domestic energy resources which are either more efficient (cogeneration) or are relatively benign environmentally (renewables like wind, solar and geothermal).

PURPA, along with market forces and other federal programs, have been successful in developing these energy sources, although

DISSENTING VIEWS ON THE MEDICAID RECONCILIATION SECTION

The reconciliation bill is supposed to be a budget-cutting vehicle. However, this package clearly demonstrates how this legislation is being used at the very last minute to include new Medicaid spending provisions which will add new financial burdens on both the Federal Government and the States. Irrespective of the various merits of these Medicaid provisions, the spending levels that these measures will produce violate any sense of restraint on increases in the Federal budget.

It should be noted that this year, for the first time, we are paying for these Medicaid expansions with spending cuts. The spending cuts in this package, which are due primarily to the "Prudent Pharmaceutical Purchasing" provision, result in greater savings than required by the budget resolution. For doing such a "good job", we are rewarding ourselves by mandating a new Medicaid expansion. This "surplus" is illusory and will ultimately have a detrimental impact on the five-year deficit reduction package. This provision provides for a phase-in of Medicaid coverage for children between the ages 7 and 18 beginning in Fiscal Year 1991. The CBO cost estimate for the various parts of this program is \$35 million in FY 91, increasing each year until FY 95 when it will cost \$330 million—resulting in a five-year cost of \$935 million. For the first five years this program will be paid for with the savings in this package. But how will it be paid for in the sixth through the twelfth years? The phase-in will not be complete until 2002.

We must also be aware that the Federal costs of these Medicaid provisions, while great, are only half the story. The States face equally large expenditures if these Medicaid expansions are enacted. Last year, 48 Governors signed a letter under the auspices of the National Governors Association asking for a moratorium on further Medicaid mandatory expansions for two years. These governors were responding to the fact that Medicaid expenditures have doubled over the past five years. The rapid growth of Medicaid expenditures is virtually causing panic in every State capital. Most States are required by their constitutions to balance their budgets. Therefore, because the Federal government is mandating these expansions, the States will have less and less discretion with respect to how they spend their limited budgets.

Given the crisis that we are facing with respect to the deficit we can not allow back door attempts to sneak in legislation that will ultimately increase Federal spending. This budget reconciliation is just the beginning. Provisions which essentially create new entitle-

ments will only balloon Federal funding and exacerbate the budget crisis. Legislating in this manner is irresponsible and we urge our colleagues to reject this package.

NORMAN F. LENT.
CARLOS J. MOORHEAD.
BILL DANNEMEYER.
THOMAS J. BLILEY, Jr.
JACK FIELDS.
MICHAEL G. OXLEY.
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SONNY CALLAHAN.
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DISSENTING VIEWS OF HON. WILLIAM E. DANNEMEYER
CONCERNING THE BUDGET RECONCILIATION PACKAGE
BEFORE THE ENERGY AND COMMERCE COMMITTEE

The Energy and Commerce Committee in this legislation has agreed to reduce overall projected Medicare Part B outlays by \$27 billion over the next five years. Most of these reductions—about \$16 billion—will come from lower reimbursement rates for physicians and other Part B providers. Approximately \$11 billion will be raised from Medicare beneficiaries by raising the Part B deductible from \$75 to \$100. The Congressional Budget Office (CBO) estimates this increase will raise \$2.6 billion over 5 years. In addition, the Committee has decided to extend current law with respect to the Part B premium, so that it continues to raise 25 percent of program expenditures.

This CBO treatment of this last change deserves special comment. Although this provision simply maintains current law, the Committee has counted this as a significant revenue raiser—\$8.6 billion over 5 years—because the provision in current law expired on October 1. In my opinion, an extension of current law should not count toward our overall deficit reduction goal. This is but one example of the “smoke and mirrors” approach in this reconciliation package.

Under this approach, many providers will be forced to restrict access to Medicare patients. As physicians receive less and less reimbursement for services provided to Medicare patients, they will conclude that it is too expensive to care for our senior citizens, and they will react by either accepting fewer and fewer Medicare patients or by forcing seniors to wait longer for care—de facto rationing.

Mr. Chairman, this is not only undesirable, it is unnecessary. If this Congress were to wield the budget ax and cut the discretionary domestic portion of the budget and foreign aid, we could achieve the Budget Summit’s goal of a balanced budget in five years with no cuts in Medicare and no new taxes. I know it may sound amazing, but this is true. I have attached some information that lays out the specifics of my budget proposal.

Every time the Congress approves a new Federal program, or increases the authorization for an existing one, we are indirectly harming the Medicare recipient. As the discretionary domestic portion of the Federal budget continues to grow, there will be more and more pressure on the Congress to exercise budgetary restraint at the expense of high quality care for seniors and others who are eligible for Medicare benefits.

My point is a simple one: Some day, all the many special interest groups that care about the future of Medicare—those who represent the Medicare patient as well as the physicians and hospitals who provide the Medicare services—will have to adopt a new strat-

egy. That strategy will require these organizations to identify specific and deep cuts in the discretionary domestic portion of the budget. They will have to confront upper middle class artists and affluent farmers in the halls of Congress. Congress will have to choose between slashing Medicare reimbursement rates or eliminating the National Endowment for the Arts.

When these confrontations arise, those portions of the budget best described as luxuries in a time of necessity will undoubtedly lose. While it may sound harsh, the Medicare community must realize that we have entered a time of budgetary zero-sum politics, where no one can win without someone else losing. I think we can all agree that it makes little sense to squeeze the Medicare program while so many other frivolous Federal programs continue to grow and prosper.

EXPANDING MEDICAID DURING A BUDGETARY CRISIS

At a time when we are about to increase the Federal debt by more than \$300 billion, it is simply inconceivable for this Committee to be expanding a Federal entitlement program. In fact, it is inconceivable that we should be expanding any Federal program at this time.

Yet the Reconciliation package does exactly that. It includes two well-intentioned, but potentially expensive expansions of the Medicaid program. Both of these proposals would expand Medicaid coverage for children. One even establishes the disturbing precedent of providing 100 percent Federal funding for a small category of eligible children, waiving for the first time the traditional State-Federal partnership. Although worthy in intent, these explanations simply perpetuate the business-as-usual atmosphere that has brought about the current budgetary stalemate.

Rather than using questionable cost estimates from the Congressional Budget Office and the Office of Management and Budget—which have embarrassed this Committee in the past—to justify the expansion of existing programs, we should be looking for ways to exceed the budgetary savings required in the budget resolution. In fact, I offered two amendments to do just this, and both were rejected by the Committee. One amendment would have allowed my home State of California to move forward with its own cost-efficient approach to nursing home reform for Medicaid recipients who reside in these facilities. The State of California estimates that its own ambitious approach would deliver the same quality of care to nursing home residents in a more cost-effective manner. Indeed, according to the CBO, my amendment would have reduced Federal Medicaid outlays by \$280 million over the next five years.

In other areas, such as the Clean Air Act, California has received an exemption from Federal regulation in order to pursue its own regulatory approach to cleaning our skies. I see nothing wrong with asking my colleagues to grant California with a similar exemption in this area.

My other amendment would have eliminated the Medicaid expansion for children up to the age of twelve. As with many other Medicaid expansions in recent years, this one begins modestly, costing only \$30 million in the first year, but rapidly escalates to more

than \$330 million annually by 1995. Again, the Committee, in its business-as-usual mode, rejected my amendment to keep the program at its present size.

The American people have written and phoned and telegraphed their utter disdain for the U.S. Congress in these last few days. To them, this is not business as usual. Indeed, it is a crisis of the first magnitude that has led many to question whether our Congress has lost the ability to function. I respectfully submit that this reconciliation package does nothing to allay these legitimate fears.

BILL DANNEMEYER.

BUDGET RECOVERY ACT

(in billions of dollars)

Functions	Fiscal year—						5 yrs
	1990	1991	1992	1993	1994	1995	
National defense:							
BA.....	299.6	289.1	289.1	289.1	289.1	289.1	.....
O.....	299.9	294.1	289.1	289.1	289.1	289.1	.....
Savings ¹		-12.4	-26.8	-36.7	-52.6	-62.4	-190.0
International affairs:							
BA.....	19.0	13.4	14.0	14.5	15.0	15.8	.....
O.....	15.5	11.9	12.6	13.0	13.1	13.8	.....
Savings ²		-5.9	-6.2	-6.4	-6.6	-6.9	-32.0
Science, space, and technology:							
BA.....	14.6	14.7	14.9	15.0	15.2	15.3	.....
O.....	14.2	14.3	14.5	14.6	14.8	14.9	.....
Savings.....		-9	-1.2	-1.5	-2.0	-2.5	-8.1
Energy:							
BA.....	4.9	4.9	5.0	5.0	5.1	5.1	.....
O.....	3.3	3.3	3.4	3.4	3.4	3.5	.....
Savings.....		-7	-1.0	-1.6	-1.9	-1.8	-7.0
Natural resources and environment:							
BA.....	17.7	18.0	18.2	18.4	18.6	18.8	.....
O.....	17.8	18.0	18.2	18.4	18.6	18.8	.....
Savings.....		-9	-1.4	-1.8	-2.0	-2.4	-8.5
Agriculture:							
BA.....	13.9	14.7	17.7	18.6	17.9	17.0	.....
O.....	12.5	13.1	13.7	14.3	14.9	14.3	.....
Savings.....		-1.0	-3.3	-1.4	-2	0	-5.9
Commerce and housing credit:							
BA.....	17.9	85.5	85.4	41.6	-6.5	2.6	.....
O.....	75.7	87.0	81.4	39.7	-9.2	-3.2	.....
Savings.....	0	0	0	0	0	0	0
Transportation:							
BA.....	31.2	31.5	31.8	32.1	32.5	32.8	.....
O.....	29.5	29.8	30.1	30.4	30.7	31.0	.....
Savings.....		-9	-1.9	-2.7	-3.6	-4.4	-13.6
Community and regional development:							
BA.....	9.8	9.2	8.9	9.0	9.5	9.6	.....
O.....	8.3	8.3	8.4	8.3	8.4	8.5	.....
Savings.....		-3	-2	-4	-5	-7	-2.1
Education, training, employment and social services:							
BA.....	40.4	42.3	43.6	44.4	46.3	48.1	.....
O.....	38.3	41.1	41.3	42.3	44.1	46.0	.....
Savings.....		-7	-1.7	-1.7	-1.3	-9	-6.3
Health:							
BA.....	61.1	66.3	73.9	81.3	89.6	98.5	.....
O.....	58.2	65.5	73.1	80.3	87.5	94.5	.....
Savings.....		0	-2	-6	-1.4	-3.0	-5.2
Medicare:							
BA.....	116.2	122.4	133.5	147.5	161.9	177.2	.....

BUDGET RECOVERY ACT—Continued

(in billions of dollars)

Functions	Fiscal year—						5 yrs
	1990	1991	1992	1993	1994	1995	
O.....	96.9	104.9	120.0	134.4	150.5	168.0	.....
Savings ³		0	0	0	0	0	0
Income security:							
BA.....	184.9	196.8	202.6	210.9	219.7	226.6	.....
O.....	148.5	155.2	162.2	169.5	177.1	185.1	.....
Savings.....		-5.3	-5.6	-5.8	-8.2	-7.1	-32.0
Social Security:							
BA.....	306.6	339.5	367.0	396.2	427.5	460.9	.....
O.....	248.7	266.3	283.7	301.4	318.9	337.2	.....
Savings.....		0	0	0	0	0	0
Veterans benefits and services:							
BA.....	30.6	31.9	33.1	34.1	35.1	36.1	.....
O.....	29.4	31.5	32.6	33.6	35.9	35.5	.....
Savings.....		-2	-1	-2	-4	-6	-1.5
Administration of justice:							
BA.....	12.4	13.5	13.6	13.8	14.0	14.2	.....
O.....	10.5	12.0	12.5	13.0	13.6	14.2	.....
Savings.....		-8	-1.7	-1.9	-1.8	-1.8	-8.0
General government:							
BA.....	12.0	11.7	11.9	11.7	11.7	11.8	.....
O.....	10.6	11.1	11.3	11.4	11.5	11.6	.....
Savings.....		-6	-7	-4	-5	-8	-3.0
Net interest: BA/O.....	181.4	193.4	201.3	207.6	208.2	205.9	.....
Savings.....		-2.4	-5.9	-9.5	-13.8	-18.5	-50.1
Und. Off. Rcpts.: BA/O.....	-36.7	-38.6	-40.7	-42.4	-44.7	-47.1	.....
Savings.....		0	0	0	0	0	0
Total:							
BA.....	1,337.5	1,460.6	1,525.7	1,549.4	1,567.2	1,640.1	.....
O.....	1,262.5	1,322.3	1,368.6	1,382.3	1,386.3	1,441.1	.....
Savings.....		-33.0	-57.9	-72.6	-96.8	-113.9	-374.2
Revenues.....	1,044.2	1,121.4	1,194.2	1,278.6	1,363.0	1,441.1	.....
Deficit ⁴	-218.3	-200.9	-174.4	-103.7	-23.3	0	.....

ADDENDA

Program savings:

Defense ¹	-12.4	-26.8	-36.7	-52.6	-62.4	-190.9	.....
Foreign aid ²	-5.9	-6.2	-6.4	-6.6	-6.9	-32.0	.....
Medicare and Medicaid.....	0	0	0	0	0	0	.....
Retirement (Social Security, Federal, military).....	0	0	0	0	0	0	.....
Unemployment.....	0	0	0	0	0	0	.....
Veterans comp. and benefits.....	0	0	0	0	0	0	.....
Other entitlements ³	-5.3	-3.7	-4.0	-5.2	-3.8	-22.0	.....
Nondefense discretionary ⁵	-7.0	-15.3	-16.0	-18.6	-22.3	-79.2	.....
Net interest.....	-2.4	-5.9	-9.5	-13.8	-18.5	-50.1	.....
Total outlays reductions.....	-33.0	-57.9	-72.6	-96.8	-113.9	-374.2	.....
Tax increases.....	0	0	0	0	0	0	.....

¹ Freezes defense spending for 5 years at fiscal year 1991 BA level assumed by BS.² Reduces annual foreign aid amounts by one-third.³ Entitlements allowed to grow annually by 9.1 percent, 5.1 percent, 5 percent, 5 percent, and 5 percent, and discretionary by 0 percent in 1991 and 1 percent each year thereafter; this results in a 4.5 percent annual cap on combined income security function.⁴ Deficit levels assumed to be revised G-R-H targets for each year.⁵ 1 percent growth generally allowed each year.

CONTENTS

	Page
I. Summary.....	229
Title XII—Outlay and Revenue Provisions Related to Spending Programs	
Within the Jurisdiction of the Committee on Ways and Means.....	229
Title XIII—Revenue Provisions.....	278
II. Detailed Explanation of Provisions.....	245

(TITLE XII—OUTLAY AND REVENUE PROVISIONS)

Subtitle A—Provisions Relating to Medicare Part A:	
1. Reductions in payments for hospital capital (section 12001).....	229
2. Prospective Payment hospitals (section 12002).....	229
3. Hospital DRG payment window (section 12003).....	231
4. Payments for graduate medical education (section 12004).....	231
5. PPS-exempt hospitals (section 12005).....	231
6. Freeze in payments under Part A through December 31, 1990 (section 12006).....	232
Subtitle B—Provisions Relating to Medicare Part B:	
1. Payments for overpriced physician procedures (section 12101-04).....	232
2. Payments for physician services (section 12105).....	233
3. Other provisions relating to physician services (section 12106-08).....	234
4. Payments for hospital outpatient services (section 12111).....	234
5. Durable medical equipment (section 12112).....	235
6. Clinical laboratory services (section 12113).....	237
7. Reduction of payments under Part B through December 31, 1990 (section 12114).....	237
Subtitle C—Provisions Relating to Medicare Parts A & B:	
1. End stage renal disease (section 12201).....	237
2. Medicare secondary payer (section 12202).....	237
Subtitle D—Provisions Relating to Medicare Part B Premium and Deductibles:	
1. Part B premium (section 12301).....	238
2. Part B deductible (section 12302).....	238
Subtitle E—User Fees	
1. Customs Service (section 12401).....	238
2. Internal Revenue Service (section 12402).....	238
3. Pension Benefit Guarantee Corporation (PBGC) (section 12403).....	238
4. Social Security Overpayments (section 12404).....	238
Subtitle F—Government-Sponsored Enterprises (section 12501-02).....	238
Subtitle G—Debt Limit Increase (section 12601).....	239

(TITLE XIII—REVENUE PROVISIONS)

Subtitle A. Increase Earned Income Tax Credit (Sec. 13101).....	239
Subtitle B. Excise Taxes	
1. Increase Excise Taxes on Distilled Spirits, Beer, and Wine (Sec. 13201).....	239
2. Increase Tobacco Excise Taxes (Sec. 13202).....	239
3. Expand Ozone-Depleting Chemicals Excise Tax (Sec. 13203).....	240
4. Increase Highway and Motorboat Fuels Excise Taxes (Sec. 13211).....	240
5. Increase Airport and Airway Trust Fund Excise Taxes (Sec. 13212).....	240
6. Increase the Harbor Maintenance Excise Tax (Sec. 13213).....	240
7. Reimpose the Leaking Underground Storage Tank Trust Fund Tax (Sec. 13214).....	240
8. Luxury Excise Tax (Sec. 13221).....	240
9. Impose Petroleum Excise Tax (Secs. 13231, 13215).....	240

	Page
Subtitle C. Other Revenue Increases	241
1. Amortization of Policy Acquisition Expenses of Insurance Companies (Secs. 13301-13303, 13307)	241
2. Treatment of Salvage and Subrogation of Property and Casualty Insurance Companies (Secs. 13305, 13307)	241
3. Compliance Provisions	241
a. Suspension of statute of limitations during proceedings to enforce certain summonses (Sec. 13311)	241
b. Apply accuracy-related penalty more effectively to section 482 adjustments (Sec. 13312)	241
c. Treatment of persons providing services (Sec. 13313)	241
d. Application of 1989 information reporting and related amendments to open years (Sec. 13314)	241
e. Information reporting by foreign corporations engaged in U.S. business (Sec. 13315)	241
f. Studies and other administrative matters (Sec. 13316)	241
4. Use of Excess Pension Plan Assets (Sec. 13321, 13325-13326)	241
5. Certain Corporate Tax Provisions	242
a. Impose corporate tax on divisive transactions in connection with certain changes of ownership (Sec. 13331)	242
b. Modify treatment of preferred stock issued with a redemption premium (Sec. 13332)	242
c. Expand and clarify reporting and allocation rules for certain acqui- sitions (Sec. 13333)	242
d. Expand the definition of a corporate equity reduction transaction for purposes of limiting certain NOL carrybacks (Sec. 13334)	242
e. Clarify treatment of debt exchanges (Sec. 13335)	242
6. Employment Tax Provisions	242
a. Increase the cap on wages and self-employment income subject to the Medicare hospital insurance payroll tax (Sec. 13341)	242
b. Extending Medicare coverage of, and application of hospital insur- ance tax to, all State and local government employees (Sec. 13342) ..	242
c. Extend Social Security retirement coverage (OASDI) to State and local government employees not covered by a public employee re- tirement program (Sec. 13343)	243
d. Increase in Railroad Retirement Tier 2 payroll taxes (Sec. 13344)	243
e. Payroll tax deposit stabilization (Sec. 13345)	243
7. Limitation on Itemized Deductions (Sec. 13351)	243
8. Deny Deduction for Interest Paid by Corporations to the IRS on Tax Obligations (Sec. 13352)	243
III. Matters Required to be Discussed Under the Rules of the House	363

I. SUMMARY

TITLE XII—COMMITTEE ON WAYS AND MEANS: SPENDING

SUBTITLE A—PROVISIONS RELATING TO MEDICARE PART A

1. Reductions in payments for hospital capital

Capital payments to Prospective Payment System (PPS) hospitals would be reduced 15 percent from cost in fiscal year 1991. Rural Primary Care Hospitals (RPCH), Essential Access Community Hospitals (EACH), and sole community hospitals would be exempted from the reductions. Capital payments to PPS-exempt hospitals would also be reduced 15 percent from cost in fiscal years 1991 and 1992.

2. Prospective Payment hospitals

(a) *Hospital Payment Adjustments.*—The hospital update factors for fiscal years 1991 through 1995 would be set as follows: fiscal year 1991, market basket minus two percentage points; fiscal year 1992, market basket minus 3.55 percentage points; fiscal year 1993, market basket minus one percentage point; fiscal years 1994 and 1995, market basket.

The disproportionate share adjustment would be increased for urban hospitals over 100 beds by increasing the multiplier in the formulas on a phased basis. For hospitals, where the disproportionate patient percentage ("P") is between 15 and 20.2, the formula would be: fiscal year 1991— $(P-15).65+2.5$; fiscal year 1992— $(P-15).65+2.5$; fiscal year 1993— $(P-15).7+2.5$; fiscal year 1994— $(P-15).8+2.5$; fiscal year 1995— $(P-15).85+2.5$. For hospitals where the disproportionate patient percentage is above 20.2, the formula would be: fiscal years 1991 and 1992— $(P-20.2).8+5.88$; fiscal year 1993— $(P-20.2).9+6.14$; fiscal year 1994— $(P-20.2).95+6.66$; fiscal year 1995— $(P-20.2)+6.92$.

The Secretary of Health and Human Services (the Secretary) would be directed not to restandardize payment amounts as a result of this amendment. Hospitals which qualify for a disproportionate share adjustment based upon revenue for indigent care received from State and local governments would receive a disproportionate share adjustment of thirty-five percent.

The disproportionate share adjustment would be made permanent. The Secretary would be directed not to restandardize payment amounts as a result of the changes in the disproportionate share adjustments made by the Omnibus Budget Reconciliation Act of 1989 (OBRA '89).

The update for hospitals in rural areas would be adjusted each year by an equal annual factor beginning with fiscal year 1991 and ending with fiscal year 1995 such that the gap between the rural

and other urban standardized amounts would be closed by the beginning of fiscal year 1995.

For fiscal year 1991, the wage index would be based 25 percent upon calendar year 1984 data, and 75 percent upon calendar year 1988 data. For fiscal years 1992 through 1993, wage indices would be based solely upon calendar year 1988 data.

The Secretary would be required to collect data on compensation and paid hours of employment in each occupational category, including compensation of contract employees, and to provide these data to the Prospective Payment Assessment Commission (ProPAC).

The regional floor would be made permanent. The Secretary would be directed to extend the regional floor on a budget-neutral basis.

(b) *Hospital Payment System Adjustments.*—Hospitals receiving disproportionate adjustments, regional referral centers, sole community providers, and EACH hospitals would be required to report statistics and costs using the uniform hospital report developed by the Secretary in the hospital reporting demonstration project.

The purpose of the Prospective Payment Assessment Commission would be defined as advising the Committees on the development of new reimbursement policies and modification of current reimbursement policies which promote the delivery of efficient, accessible, high-quality health care. The Commission would be directed to focus on payment to institutional providers, including hospitals, outpatient departments, skilled nursing facilities, ambulatory surgery centers, and others which may be defined in the future.

With respect to PPS, ProPAC would be required to recommend a hospital update factor, as well as other proposed changes in current Medicare reimbursement systems to the House Committee on Ways and Means and Senate Committee on Finance (the Committees) by March 1 of each year. The Secretary would continue to be required to make an independent recommendation on the update by March 1. ProPAC would be required to report each year by June 1 on Medicare PPS and the health care system. This report would report generally on issues and problems with the health care system as a whole, and with hospitals and other institutional providers. The Office of Technology Assessment (OTA) Director's authority to appoint ProPAC Commissioners would be modified to clarify that the professions listed for membership of the Commission are illustrative, not determining. The required OTA report to Congress would be eliminated. The requirement for the report to Congress on the Secretary's adjustments to PPS would be eliminated.

The provision of OBRA '86 authorizing the Secretary to reduce payments to hospitals and skilled nursing facilities would be repealed.

Payments to hospitals for the routine costs of extended care services ("swing beds") in rural areas in a region would be limited to the payments for such costs under the Medicare program for free-standing skilled nursing facilities in such areas in the region. The limit would be based on costs in the most recent year for which data are available, trended forward in the same manner as the limits currently applicable to skilled nursing facilities paid on a

prospective basis. However, if this limit reduces payment in any region, hospitals in that region would receive the current level of payment until the limit provided by this section exceeded current payment.

3. Hospital Diagnosis Related Group (DRG) payment window

In order to curb further unbundling which has occurred since the introduction of Medicare's hospital DRG payment system, services provided on the day of a hospital admission, and for up to 72 hours prior to the day of admission, would not be separately reimbursable under Part B, if Part A is the primary payer for the admission. Medicare carriers would be responsible for assuring that payment was not made under Part B for these services.

4. Payments for graduate medical education (GME)

Medicare pays for the direct costs of GME based upon an average amount per full-time equivalent (FTE) resident. Under the proposal, in determining the number of FTE residents, each FTE resident beyond the initial three years of training in any specialty would be counted as 0.80 FTE. Each FTE resident in the initial period of training in specialties other than family medicine, internal medicine and pediatrics would be counted as 0.90 FTE. Each FTE resident in the initial period of training in internal medicine and pediatrics would be counted as 1.00 FTE.

Each FTE resident being specifically trained in primary care, as designated by the Secretary, would be counted as 1.10 FTE. Primary care specialties would be family medicine, general internal medicine and general pediatrics.

The approved amount per FTE resident would be limited in each year to a set percent of the national median, adjusted for local costs, of the hospital-specific approved FTE resident amounts. The limiting percentages would be 200 percent in fiscal year 1992, 175 percent in fiscal year 1993, and 150 percent in fiscal year 1994.

5. PPS-exempt hospitals

The Secretary would be directed to develop a new prospective payment methodology for exempt hospitals, or to modify substantially the current target rate system. The Secretary would be directed to report to the Committees his proposals to modify or replace the current system by February 1, 1991. ProPAC would be directed to report to the Congress with comments on the Secretary's proposal by May 1, 1991.

The Contractor Performance and Evaluation standards would be amended to require fiscal intermediaries to evaluate and forward to the Health Care Financing Administration (HCFA), with recommendations, applications by exempt hospitals for exceptions and adjustments to the target rates within 60 days of filing of a completed application, unless further information is required by the intermediary.

The grounds on which the Secretary may grant an appeal for an exception and adjustment to the cost limits enacted in the Tax Equity and Fiscal Responsibility Act of 1982 would be clarified. The grounds would include, but not be limited to: a change in applicable technology, medical practice, or case mix severity which in-

creases costs above the target rate; or a change in wages and wage-related costs in the geographic area of the hospital in excess of the change nationally in wages paid by hospitals.

6. Freeze in payments under Part A through December 31, 1990

Payments to hospitals and hospices would be frozen at fiscal year 1990 levels. This would be accomplished by continuing the fiscal year 1990 standardized amounts, wage indices, and regional floor, and by continuing the fiscal year 1990 reduction in capital costs of 15 percent. The update in payment for hospices would be delayed to January 1, 1991.

SUBTITLE B—PROVISIONS RELATING TO MEDICARE PART B

1. Payments for overpriced physician procedures

(a) *Overpriced Procedures.*—Procedures identified as overpriced in OBRA '89 would be reduced by the same amount as such procedures were reduced under the 1989 Act. As OBRA '89 reduced the amount these procedures were overpriced by one-third, the reduction under this provision would reduce the amount these procedures are overpriced by an additional one-third, or one-half of the remaining amount, effective January 1, 1991.

Services not included in the first phase of the Harvard resource based relative value scale (RB RVS) study, and not reviewed by the Physician Payment Review Commission, would have their prevailing charges reduced by five percent, effective January 1, 1991.

(b) *Radiology Services.*—The local conversion factors used for payments under the radiology fee schedule would be reduced by up to 15 percent, effective January 1, 1991. The amount of the reduction in each locality would be calculated as follows: (1) the national average conversion factor that applied after April 1, 1990, would be reduced by six percent; (2) a local reduced conversion factor amount would be estimated by adjusting the overhead and work components of the reduced national average conversion factor by a geographic practice cost index (GPCI) and physician work geographic index in the same manner as under the RB RVS; and (3) the local conversion factor would be reduced to the adjusted local amount, up to a maximum reduction of 15 percent. If the local conversion factor was less than the adjusted local amount, the local conversion factor would not be changed.

The prevailing charges of radiology services not reimbursed under the fee schedule would be reduced to the fee schedule amount.

The relative values under the radiology fee schedule for CAT (computerized axial tomography) scans and MRI (magnetic resonance imaging) scans would be reduced by 10 percent.

Carriers would be prohibited from applying the comparable fee rule to services under both the radiology and anesthesiology fee schedules, effective with implementation of the RB RVS on January 1, 1992.

(c) *Anesthesiology Services.*—The local conversion factors used for payments for physician anesthesia services would be reduced by up to 15 percent, effective January 1, 1991. The amount of the reduction in each locality would be calculated as follows: (1) the national

average conversion factor that applied after April 1, 1990, would be reduced by six percent; (2) a local reduced conversion factor amount would be estimated by adjusting the overhead and work components of the reduced national average conversion factor by a GPCI and physician work geographic index in the same manner as under the RB RVS; and (3) the local conversion factor would be reduced to the adjusted local amount, up to a maximum reduction of 15 percent. If the local conversion factor was less than the adjusted local amount, the local conversion factor would not be changed.

The reduction in payments to anesthesiologists for supervising multiple concurrent services by CRNAs would be extended through December 31, 1995.

(d) *Pathology Services.*—Payments for pathology services would be reduced by six percent, effective January 1, 1991. The requirement to implement the pathology fee schedule on January 1, 1991, would be repealed. Pathology services would be paid under the RB RVS beginning January 1, 1992.

2. *Payments for physician services*

(a) *Physician and Primary Care Services.*—The update for all reasonable charge fee screens and fee schedules would be equal to the Medicare Economic Index (MEI) for primary care services, and zero percent for all other services. The MEI that would apply on January 1, 1992, would be reduced by 0.4 percent from the amount that would otherwise apply. Under current estimates, this would provide for an update of two percent in 1992.

The lower limit on prevailing charges for primary care services would be set at 75 percent of the national average prevailing charge for primary care services rendered during calendar year 1991. In 1992, fees for services that were increased by this provision would be determined without regard to the increase in the primary care floor, except that no such fee could be lower in 1992 than in 1991.

The existing authority for the Physician Payment Review Commission would be amended to provide for consideration of a variety of issues, including: implementation of the RB RVS; further development of the volume performance standard system, payment incentives to increase access to primary care and other services in innercity and rural areas, the number and types of physicians being trained, physician licensing and certification, and medical malpractice.

(b) *Physician Medicare Volume Performance Standards.*—The Medicare Volume Performance Standards (MVPS) would be set at the baseline rate of growth in expenditures for fiscal years 1991 through 1995. Under current estimates, the overall MVPS would be 8.5 percent for fiscal year 1991, 9.0 percent for 1992, 9.1 percent for 1993, and 11.1 percent for 1994 and 1995. These rates of growth are consistent with reductions of 1.0 percent in 1991, 1.5 percent in 1992, and 2.0 percent in 1993, 1994 and 1995. The surgical and non-surgical MVPS standards would vary from this estimated only to reflect the relative impact of this bill, and regulations that may be issued by the Department, including the RB RVS, on expenditures for services within each category. The standards for these catego-

ries would assume the same rate of growth in volume of surgical and non-surgical services.

The final determination of the MVPS standards would be adjusted to reflect the final estimates and distribution of savings resulting from this bill.

3. *Other provisions relating to physician services*

(a) *New Physicians.*—The customary charges of new physicians in 1991 would be limited to 80/85/90/95 percent in the first through fourth years of practice, respectively. Beginning on January 1, 1992, these percentage limits for new physicians in their first through fourth years of practice would apply to the amounts recognized under the RB RVS.

(b) *Payments for Assistant-at-Surgery Services.*—Physicians acting as an assistant at surgery for a procedure that routinely involves the use of an assistant would be paid under current policy. A procedure would be considered as routinely involving the use of an assistant if an assistant is sued in more than 50 percent of such cases, nationwide.

When a procedure has a variable use of an assistant, for between 25 and 50 percent of cases, the fee for the assistant would be reduced to 15 percent of the prevailing charge.

If a procedure infrequently requires use of an assistant, for between 5 and 25 percent of cases, the fee for the assistant would be reduced to 15 percent of the prevailing charge, and would require prior authorization from a Peer Review Organization.

Payments would not be made for an assistant at surgery if an assistant is used in fewer than five percent of cases.

(c) *Interpretation of Electrocardiographs (EKGs).*—Payments for the interpretations of EKGs would be treated the same as other simple diagnostic tests under the RB RVS, effective January 1, 1992. That is, the interpretation would be considered to be part of an office or hospital visit. This provision would be effective on January 1, 1992, after the increase in payments for office and hospital visits are made under the RB RVS. Separate payments would not be made except when the EKG is not performed in conjunction with an office or hospital visit. Payments would continue to be made for the technical component of EKGs on an outpatient basis.

4. *Payments for hospital outpatient services*

(a) *Capital.*—Capital payments for hospital outpatient services would be reduced 15 percent from cost in fiscal year 1990. Sole community, EACH and RPCH hospitals would be exempt from the reduction.

(b) *Outpatient Services on a Cost-Related Basis.*—Payments for services on a cost-related basis would be reimbursed at 98 percent of costs. Sole community hospitals, EACH and RPCH hospitals would be exempt from the reduction.

The Secretary would provide for the development of a proposal for paying for hospital outpatient services under a prospective payment system. In developing this proposal, the Secretary would consider policies which provide appropriate limits on growth, adjustments to account for changes in types of patients treated, volume, technology, and medical practice, provide incentives for hospitals to

control costs, and other issues. The Secretary would consider whether payments for the same service should vary by the type of facility in which the service is provided, such as between free-standing facilities and hospital based outpatient departments. In considering the impact of new technology on the cost of outpatient services, the Secretary would pay particular attention to issues raised by the impact of new technologies on the costs of intra-ocular lenses (IOLs), including whether additional payments or special adjustments are warranted for so-called "high technology lenses."

The HCFA Administrator would provide the Committees with summaries of existing research findings by January 1, 1991. The Secretary would submit a detailed proposal to the Committees by September 1, 1991. ProPAC would submit a report by March 1, 1992.

(c) *Payments for Ambulatory Surgery and Radiology.*—Ambulatory surgical services and radiology services in hospital outpatient departments would be subject to aggregate cost limits based on a blend of 33 percent of the hospital's own costs, and 67 percent of the fees for the same services provided outside of the hospital setting, effective January 1, 1991. The special limit for ambulatory surgery provided in eye, and in eye-and-ear-specialty hospitals would be extended through 1995.

In determining the payment rates for free-standing ambulatory surgical facilities, the Secretary would recognize an allowance of \$200 per IOL, effective on enactment through December 31, 1992.

5. *Durable medical equipment (DME)*

(a) *Overpriced DME.*—The fees for seatlift chairs and transcutaneous electrical nerve stimulation (TENS) devices would be reduced by 15 percent, effective January 1, 1990.

(b) *Limits on Variations in Fees.*—The regional fees would be repealed. National upper- and lower-fee limits would be established for all categories of DME except for customized equipment, and local fees above or below these limits would be phased to the limiting amount in 1993.

The upper limits for an item would be the weighted average of the fee schedule amounts that apply in 1991. In 1991 and 1992, payments would be capped by a blend of the local fee schedule amount and the national limit. In 1991, the blend would be based on 67 percent of the local fee and 33 percent of the national limit. In 1992, the blend would be based on 33 percent of the local fee and 67 percent of the national limit. In 1993, the fee schedule amounts in areas that exceed the upper limit would be set at the national limit.

National fee "floors" for an item would be defined as 85 percent of the national upper limits in 1991. In 1991 and 1992, payments would be subject to a lower limit equal to a blend of the local fee schedule amount and the national fee floor. In 1991, the blend would be based on 67 percent of the local fee and 33 percent of the national floor. In 1992, the blend would be based on 33 percent of the local fee and 67 percent of the national floor. In 1993, the fee schedule amounts in areas that are below the national floor would be set at the floor.

Fees in areas that are between the average and 85 percent of the average would not be effected by this provision.

(c) *Cap on Rental Items*.—Payments for the rental of DME would be based on a fee schedule equal to ten percent of the average allowed purchase price in a base period for the first three months of rental and 7.5 percent of the average allowed purchase price for the fourth through fifteenth months of rental.

The Secretary would be required to establish the reasonable useful lifetime of rental items. A new cycle of rental payments would be allowed for replacement equipment.

Patients would be given an opportunity to purchase rental equipment in the tenth month of rental, in which case payments would continue through the thirteenth month.

Non-customized motorized wheelchairs would be recategorized back into the rental cap category of equipment. The option for treating wheelchairs as customized would not be changed.

If the Secretary does to issue regulations defining "customized" wheelchairs by January 1, 1992, a statutory definition would become effective.

(d) *Oxygen Retesting*.—Beneficiaries that qualify for oxygen therapy for an initial period of three months would be retested to confirm their continued need for oxygen use, prior to continuing payments for oxygen therapy beyond the initial three months.

(e) *Useful Lifetime of Rental Equipment*.—A reasonable useful lifetime of rental and frequently serviced items would be established. The useful lifetime would be five years, unless the Secretary finds, based on program experience, that a longer or shorter period is appropriate for an item. After an item's useful lifetime is reached during a continuous period of medical necessity, the Secretary would provide for a new cycle of rental payments. Carriers would be permitted to begin an earlier cycle of new rental payments for equipment that is lost or irreparably damaged.

(f) *DME Update*.—The update for DME would be reduced by one percent in 1991 and 1992.

(g) *Enteral and Parenteral Equipment and Supplies*.—Payment levels for enteral and parenteral equipment and supplies would not be updated for 1991.

(h) *Administrative Procedures*.—Suppliers would be prohibited from distributing completed or partially completed Medicare medical necessity forms. Suppliers who distribute such forms would be subject to civil monetary penalties.

For customized equipment and for equipment designated by the Secretary as requiring a prior written physician's order, suppliers could request prior approval of the item from a carrier in a form determined by the Secretary. The Secretary would establish standards for the timeliness of carrier responses to such requests, and would incorporate such standards into the evaluations of carriers' performance.

Claims for item of DME that are potentially overused would be subject to special carrier scrutiny. The Secretary would publish, and periodically update, a list of such items. The list would include: seatlift chairs, TENS equipment, power-driven scooters, and such other items of DME as determined appropriate by the Secretary. The Secretary would include items that are: (1) mass marketed di-

rectly to beneficiaries; (2) marketed with offers to waive the coinsurance, or marketed as "free" or "at no cost" to beneficiaries with Medigap coverage or other coverage; (3) subject to a consistent pattern of overutilization; and (4) frequently denied based on a lack of medical necessity.

(i) *Orthotics and Prosthetics*.—Payments for orthotics and prosthetics would be recodified in a separate subsection of law. The current requirements relating to regional fees would be delayed by one year. Otherwise, payments would be made on the same basis as under current law.

The update for orthotic and prosthetic fees would be reduced to zero percent for 1991.

The General Accounting Office (GAO) would conduct a study of payments for orthotic and prosthetic items and services under Medicare.

6. Clinical laboratory services

(a) *Laboratory Fee Schedule Update*.—The update for clinical laboratory services would be reduced to two percent.

(b) *Payments for Laboratory Services*.—The limit on clinical laboratory fee schedules would be reduced from 93 to 88 percent of the median of local fee schedules.

7. Reduction of payments under Part B through December 31, 1990

Program payments under Part B would be reduced by 1.4 percent for services provided on or after November 1, 1990, and on or before December 31, 1990. Beneficiary liability for Part B cost-sharing would be unaffected by this reduction in the same manner as under a sequester order.

SUBTITLE C—PROVISIONS RELATING TO MEDICARE PARTS A AND B

1. End stage renal disease

The Secretary would establish a rate for hospital and free-standing facilities not less than the rate in effect September 30, 1990. This provision would expire December 31, 1995.

The Secretary would be directed to revise payments for erythropoietin. Payments would be based upon 1,000 unit increments. The Secretary would make payments of no more than \$11.00 per 1,000 units, up to a maximum payment of \$70 per dose. Beginning in fiscal year 1992, the payment level for erythropoietin would be indexed to the GNP deflator. The Secretary would continue to make payments as an add-on to the composite rate.

2. Medicare secondary payer

As a result of changes made in OBRA '89, the Department of Health and Human Services is able to use data provided by the Social Security Administration and the IRS to improve identification and collection of Medicare secondary-payer cases. This information is particularly useful for identifying spouses of beneficiaries who may be covered by an employer health plan. This provision, scheduled to expire after September 30, 1991, would be extended through September 30, 1995.

Medicare is secondary payer for disability beneficiaries who are covered by a "large group health plan." A large group health plan may not take into account that an active, disabled individual is entitled to this provision. This provision, scheduled to expire before January 1, 1992, would be extended through September 30, 1995.

SUBTITLE D—PROVISIONS RELATING TO MEDICARE PART B PREMIUM AND DEDUCTIBLE

1. Part B premium

The Part B premium would be set as follows: \$32.40 in 1991, \$36.00 in 1992, \$40.50 in 1993, \$44.00 in 1994 and \$46.50 in 1995.

2. Part B deductible

The Part B deductible would be increased to \$100 in 1991, \$125 in 1992 and in subsequent years.

SUBTITLE E—USER FEES

1. Customs Service

The Committee agreed to extend the provisions of Subtitle B of the Customs and Trade Act of 1990 (P.L. 101-382) for four years until December 31, 1995.

2. Internal Revenue Service

The Committee agreed to extend for five years, effective September 30, 1990, the IRS user fee program which expired on September 29, 1990.

3. Social Security Overpayments

Recovery of Overpayments from Former Social Security Beneficiaries through Tax Refund Offset.—The Social Security Administration would be authorized to recover overpayments from former social security beneficiaries by having the IRS offset the former beneficiary's tax refund. This authority would remain in effect so long as the existing Government-wide tax refund offset program remains in effect (currently, until January 10, 1994).

4. Pension Benefit Guaranty Corporation (PBGC) Premium

The Committee agreed to increase per-participant premiums payable to the PBGC by employers who maintain defined benefit pension plans. Under present law, the premium equals \$16.00 per participant. In addition, a variable rate premium for underfunded plans under present law equals \$6.00 per \$1,000 of unfunded liability per participant; the variable rate premium is capped at \$34.00. The Committee agreed to raise the basic premium to \$19.00 per participant; and the variable rate to \$9.00 per \$1,000 of unfunded liability, capped at \$53.00 per participant. The increase is effective for plan years beginning after December 31, 1990.

SUBTITLE F—GOVERNMENT-SPONSORED ENTERPRISES

The Committee agreed to require that the Department of the Treasury report annually on the financial safety and soundness of

Government-sponsored enterprises. The Treasury report would be submitted to the Congress on March 15 of each year.

Further, the Committee agreed that borrowing by any newly-created corporation owned in whole or in part by the Federal Government, or any privately-owned Government-sponsored enterprise, must be in amounts explicitly authorized by law and must be directly from the Department of the Treasury (to include the Federal Financing Bank). These provisions are identical to H.R. 3469, the Federal Debt Management Act, which was ordered favorably reported to the House by the Committee on Ways and Means on March 28, 1990. This provision would be effective for all such entities established pursuant to any law enacted after October 10, 1990.

SUBTITLE G—DEBT LIMIT INCREASE

The budget resolution instructed the Committee on Ways and Means to increase the permanent statutory limit on the public debt by an amount not to exceed \$1.9 trillion.

The Committee increased the public debt limit by \$1,377.3 billion, effective on enactment through September 30, 1993. On October 1, 1993, the public debt limit would increase an additional \$500 billion.

TITLE XIII—REVENUE PROVISIONS

SUBTITLE A—INCREASE EARNED INCOME TAX CREDIT

The Committee agreed to a provision to modify the Earned Income Tax Credit in a manner that increases the expenditure related to the credit by \$5 billion over five years. The increase is effective beginning after December 31, 1990.

SUBTITLE B—EXCISE TAXES

1. *Increase Excise Taxes on Distilled Spirits, Beer and Wine*

The Committee agreed to increase the excise tax rate on alcohol as follows: (a) *distilled spirits*, increase from \$12.50 to \$14.00 per proof gallon; (b) *beer*, increase from 16 cents to 32 cents per six pack; (c) *wine*, increase from 3 cents to 25 cents per 750-milliliter bottle; (d) *fortified wine*, increase from 13 cents to 35 cents per 750-milliliter bottle (for wine with 14 to 21 percent alcohol content), and from 45 cents to 67 cents per 750-milliliter bottle (for wine with 21 to 24 percent alcohol content); and (e) *artificially carbonated wine*, increase from 48 cents to 70 cents on a 750-milliliter bottle.

2. *Increase Tobacco Excise Taxes*

The Committee agreed to increase the current excise taxes on all tobacco products by 25 percent effective January 1, 1991 (e.g., the tax on a pack of 20 small cigarettes would be increased from 16 cents to 20 cents). The Committee also agreed to further increase the excise taxes on all tobacco products by the same dollar amount as the previous 25-percent increase effective January 1, 1993 (e.g., the tax on a pack of 20 small cigarettes would be increased from 20 cents to 24 cents).

could not reduce assets in the pension plan below 150 percent of current liability, or accrued liability if less, but in no case less than 125 percent of current liability. In addition, the Committee agreed to a number of modifications to the excise tax on reversions of overfunded pension plans. Under the agreement, the excise tax on reversions is increased from 15 percent under current law to 50 percent. Alternatively, the employer may elect to pay a 20-percent excise tax and transfer 30 percent of the reversion into a new pension plan. The employer could also elect to pay a 20-percent excise tax, and provide for benefit increases, allocated among active participants and retirees, equal to 25 percent of the excess assets in the terminated plan.

The provisions with respect to asset transfers into retiree health accounts is effective for transfers in taxable years beginning after December 31, 1990.

The modifications to the excise tax on asset reversions are generally effective for reversions occurring after September 30, 1990, except for any reversion for which a notice of intent to terminate was provided to participants on or before September 30, 1990.

5. Certain Corporate Tax Provisions

The Committee agreed to a series of business tax provisions, including provisions to (a) expand and clarify reporting and allocation rules for certain asset acquisitions; (b) require the accrual of redemption premium of certain preferred stock; (c) expand the definition of a corporate equity reduction transaction (CERT) to include the acquisition of 50 percent or more of the stock of a subsidiary of another corporation (unless an election under Code section 338 was made to treat the acquisition as an acquisition of assets); (d) impose corporate level tax on divisive transactions in connection with certain changes of ownership if, after the distribution of a subsidiary, a shareholder holds at least 50 percent of the stock of a corporation involved in the transaction (generally, the distributing corporation or the distributed subsidiary), provided that the shareholder's 50-percent ownership is attributable to stock the shareholder acquired directly or indirectly in a purchase or certain similar transactions within the previous five years; and (e) clarify and modify the treatment of certain debt-for-debt exchanges and certain preferred stock-for-debt exchanges.

6. Employment Tax Provisions

A. Increase the Cap on Wages and Self-Employment Income Subject to the Medicare Hospital Insurance Payroll Tax

The Committee agreed to increase the cap on wages subject to the HI payroll tax to \$73,000 for 1991, as compared with a projected \$54,300 under present law. As under present law, the cap is indexed according to changes in average wages in the economy.

B. Coverage of State and local Government Employees Under Medicare

The Committee agreed to a provision requiring coverage of State and local government employees under Medicare. Medicare hospital insurance (HI) tax is phased-in so that the employer and em-

ployee each pays a tax of .8 percent in 1992 (1.6 percent total); 1.35 percent in 1993 (2.70 percent total); and 1.45 percent in 1994 and thereafter (2.9 percent total).

C. Extend Social Security Retirement Coverage to State and Local Employees not Covered by a Pension Plan

The Committee agreed to a provision requiring Social Security coverage for State and local employees who are not covered under a retirement plan offered by a State or local employer. The provision is effective with respect to services performed after September 30, 1990.

D. Increase in Railroad Retirement Tier 2 Payroll Taxes

The agreement assumes an increase in the Railroad Retirement Tier 2 tax rate of 0.40 percent on the Tier 2 wage base (capped at \$38,100 in 1990). In the alternative, the rate would be recalculated at current rates, but would attribute employer contributions on a rolling 10-year base to account for the reduced number of rail employees and thus greatly reduced contributions by some railroads. The provision would be effective on January 1, 1991.

E. Payroll Tax Deposit Stabilization

The Committee agreed to an amendment to provide that employer deposits of withheld income and payroll taxes equal to or greater than \$100,000 must be made by the close of the next banking day for all calendar years. The provision is effective for amounts required to be deposited after December 31, 1990.

7. Limitation on Itemized Deductions

The Committee agreed to a provision to reduce a taxpayer's allowable itemized deductions (other than medical expenses and investment interest) by an amount equal to 3 percent of the taxpayer's adjusted gross income (AGI) in excess of \$100,000. The \$100,000 threshold applies to married couples filing jointly, unmarried individuals, and heads of households. In no event would this provision reduce itemized deductions subject to the provision by more than 80 percent.

8. Corporate Interest Deductions

The Committee agreed to deny a deduction for interest paid by a corporation to the IRS on underpayments relating to any type of Federal tax. The provision applies to interest economically accruing after December 31, 1990.

II. DETAILED EXPLANATION OF PROVISIONS

TITLE XII—COMMITTEE ON WAYS AND MEANS: SPENDING

Subtitle A—Provisions Relating to Medicare Part A

Sec. 12001—Reductions in Payments for Capital-Related Costs of Inpatient Hospital Services for Fiscal Year 1991

Present Law

Capital-related costs (including depreciation, interest, and rent) are excluded from the Prospective Payment System (PPS) until September 30, 1991. Until that time, capital costs continue to be reimbursed on a cost basis.

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) reduced payment amounts for capital-related costs by twelve percent for fiscal year 1988 beginning January 1, 1988, and fifteen percent for fiscal year 1989. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) reduced payment amounts by fifteen percent for fiscal year 1990, beginning January 1, 1990. Sole community hospitals and Essential Access Community Hospitals (EACH) are exempted from capital-related payment reductions. Current law would pay hospitals 100 percent of their capital-related costs in fiscal year 1991.

Explanation of Provision

Capital-related payment amounts would be reduced by fifteen percent in fiscal year 1991. Rural Primary Care Hospitals would be exempted from the reductions. Sole community providers and EACHs would continue to be exempted from the reductions.

The Committee notes that capital-related payments are excluded from PPS through September 30, 1991. The Secretary is required to develop a system for reimbursing capital on a prospective basis prior to that date. The Committee intends to review the Secretary's proposal at such time as the Secretary issues a notice of proposed rule-making on capital reimbursement. The Committee would anticipate holding a public hearing at that time.

The Committee notes that the Congressional Budget Office (CBO) currently projects that the total expenditures under Part A will increase from \$66.8 billion to \$74.7 billion, an increase of 11.7 percent, between FY 91 and FY 92, after implementation of the proposed reductions in payment incorporated in this report. Given this rate of increase, the Committee believes there is more than sufficient flexibility to assess, and to adjust as appropriate, capital payment policy prior to October 1, 1991.

Effective Date

Effective for portions of cost reporting periods beginning October 1, 1990.

*Sec. 12002—Prospective Payment Hospitals**Present Law*

Current law provides that for fiscal year 1991 and subsequent years hospital payments per discharge for all Prospective Payment System (PPS) hospitals will be increased at a rate equal to the hospital market basket index percentage increase. The hospital market basket index is an inflation index developed by the Secretary to reflect increases in the costs of goods and services purchased by hospitals.

The Secretary is required to recommend to the Congress an appropriate factor to be used to update the large urban, other urban, and rural standardized amounts which are the basis for payment for hospitals in each type of area. The recommendation must take into account amounts necessary for the effective and efficient delivery of medically appropriate and necessary care of high quality. The Secretary has recommended an update of the increase in the market basket index minus 1.75 percentage points for urban hospitals and the full increase in the market basket index for rural hospitals in fiscal year 1991.

Disproportionate share payments are made to an urban hospital with 100 or more beds if its share of low income patients equals or exceeds fifteen percent. The adjustment is increased by 0.6 percentage points for each 1.0 percent increase in the proportion of low income patients between 15 and 20.2 and .65 for each 1.0 percent above 20.2. Thus the adjustment is based upon the formula $(P-15) \cdot .6 + 2.5$ or $(P-20.2) \cdot .65 + 5.62$ respectively, where "P" is the proportion of low income patients.

Certain other urban hospitals qualify for a disproportionate share adjustment if the hospital is in an urban area, has more than 100 beds, and can demonstrate that its net inpatient care revenues from other than Medicare and Medicaid payable by State and local governments for indigent care exceed thirty percent of the hospital's net inpatient revenue. These hospitals receive a disproportionate share adjustment of thirty percent.

The disproportionate share adjustment expires at the end of fiscal year 1995.

No specific provision regarding restandardization of payment amounts relative to changes in the disproportionate share adjustments was included in OBRA '89.

Under current law rural hospitals would receive the same update factor as other PPS hospitals, the rate of increase in the hospital market basket index.

The proportion of the standardized amount which relates to labor costs is adjusted to take into account differences between areas in salaries and wages. OBRA '87 directed the Secretary to create a new wage index for fiscal year 1991. In a notice of proposed rule making, the Secretary has proposed a new wage index based upon calendar year 1988 data which will be effective October 1, 1990.

If the regional standardized amount for large urban, other urban, or rural hospitals in a region is higher than the national standardized amount for such hospitals, payment to those hospitals in that region is based upon 85 percent of the national standardized amount and upon 15 percent of the regional standardized amount for fiscal years beginning with fiscal year 1988 and ending with fiscal year 1990.

OBRA '86 authorized the Secretary to reduce the amount of payments otherwise payable to hospitals and skilled nursing facilities in order to avoid duplicate payments for services provided by physician assistants.

Reimbursement to hospitals for extended care services in swing beds is limited to the average of the Medicaid skilled nursing facility rates for the state. However, OBRA '87 eliminated separate payment rates for skilled nursing facilities under Medicaid.

OBRA '87 directed the Secretary to develop a uniform hospital reporting demonstration project in two states. In those states, California and Colorado, hospitals are required to report hospital statistical and cost information using a uniform reporting format developed by the Secretary.

The Prospective Payment Assessment Commission (ProPAC) is required to consult with and make recommendations to the Secretary and evaluate any actions of the Secretary regarding classification and weighting of diagnosis-related groups (DRGs) and report to the Congress.

By March 1 of each year, ProPAC is required to report to the Secretary its recommendations for the hospital update factor. The Secretary, by March 1 of each year, is required to report to the Congress his recommendation for the update factor, taking ProPAC's recommendation into account. By May 1 of each year, the Secretary is required to publish an updated recommendation on the update for public comment.

In addition to its other responsibilities, ProPAC is required to collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice and lengths of stay and on other patient-care data. ProPAC is required to give special attention to analysis related to updating or creating new DRGs or changing the DRG weights.

In selecting the ProPAC Commissioners, the Director of the Office of Technology Assessment (OTA) is directed to include national experts, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and registered professional nurses, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care.

The OTA is required to report annually to Congress on the functioning and progress of the Commission. ProPAC is required to report to the Congress on its evaluation of adjustments made to PPS by the Secretary each year.

Explanation of Provisions

The hospital update factors for fiscal years 1991 through 1995 would be set as follows: FY '91: market basket minus two percentage points; FY '92: market basket minus 3.55 percentage points; FY '93: market basket minus one percentage point; FY '94 and FY '95: market basket.

The disproportionate share adjustment would be increased for urban hospitals over 100 beds by increasing the multiplier in the formulas on a phased in basis.

For hospitals where the disproportionate patient percentage ("P") is between 15 and 20.2, the formula would be: FY '91— $(P - 15) .65 + 2.5$; FY '92— $(P - 15) .65 + 2.5$; FY '93— $(P - 15) .7 + 2.5$; FY '94— $(P - 15) .8 + 2.5$; FY '95— $(P - 15) .85 + 2.5$.

For hospitals where the disproportionate patient percentage ("P") is above 20.2, the formula would be: FY '91 and FY '92— $(P - 20.2) .8 + 5.88$; FY '93— $(P - 20.2) .9 + 6.14$; FY '94— $(P - 20.2) .95 + 6.66$; FY '95— $(P - 20.2) + 6.92$.

The Secretary would be directed not to restandardize payment amounts as a result of this amendment. Hospitals which qualify for a disproportionate share adjustment based upon revenue for indigent care received from State and local governments would receive a disproportionate share adjustment of thirty-five percent.

The disproportionate share adjustment would be made permanent. The Secretary would be directed not to restandardize payment amounts as a result of the changes in the disproportionate share adjustments made by OBRA '89.

The update for hospitals in rural areas would be adjusted each year by an equal annual factor beginning with fiscal year 1991 and ending with fiscal year 1995 such that the gap between the rural and other urban standardized amounts would be closed by the beginning of FY '95.

For the last nine months of fiscal year 1991, the wage index would be based 25 percent upon calendar year 1984 data and based 75 percent upon calendar year 1988 data. For fiscal years 1992 through 1993 wage indices would be based solely upon calendar year 1988 data.

The Secretary would be required to collect data on compensation and paid hours of employment in each occupational category, including compensation of contract employees, and to provide these data to the Prospective Payment Assessment Commission (ProPAC).

Based on these data the Secretary would be required to analyze and make recommendations to Congress on adjusting the area wage index for occupational mix by June 1, 1993. By September 1, 1993 ProPAC would be required to report to Congress on the Commission's recommendations for adjusting the area wage index for occupational mix, as well as other adjustments, including (but not limited to) redefining geographic areas for purposes of the wage index and the inclusion or exclusion of compensation of contract employees in the data used to construct the area wage index.

The regional floor would be made permanent. The Secretary would be directed to extend the regional floor on a budget-neutral basis.

The provision of OBRA '86 authorizing the Secretary to reduce payments to hospitals and skilled nursing facilities would be repealed.

Payments to hospitals for the routine costs of extended care services in rural areas in a region would be limited to the payments for such costs under the Medicare program for free-standing skilled nursing facilities in such areas in the region.

The limit would be based on costs in the most recent year for which data are available trended forward in the same manner as are the limits currently applicable to skilled nursing facilities paid on a prospective basis. However, if this limit reduces payment in any state, hospitals in the state would receive the current level of payment until the limit provided by this section exceeded current payment.

Hospitals receiving disproportionate share adjustments, regional referral centers, sole community providers, and EACH hospitals would be required to report statistics and costs using the uniform hospital report developed by the Secretary in the hospital reporting demonstration project authorized by OBRA '87.

The purpose of the Prospective Payment Assessment Commission would be defined as advising the Committees on the development of new reimbursement policies and modification of current reimbursement policies which promote the delivery of efficient, accessible, high-quality health care. The Commission would be directed to focus on payment to institutional providers, including hospitals, outpatient departments, skilled nursing facilities, ambulatory surgical centers, and others which may be defined in the future.

In performing this function, ProPAC would be required to analyze and recommend changes in policies regarding: (1) payment of inner-city hospitals, including appropriate recognition of bad debt and charity care costs and adequacy of Medicaid payment levels; (2) payment of rural hospitals including recommendations on appropriate responses to problems with low occupancy, quality of care, and barriers to access to health care services in rural areas; and (3) policies which help constrain the costs of health care to employers, including changes in Medicare and in payment policies affecting other payers.

ProPAC would be directed to advise the Committees on new Medicare prospective payment programs including hospital-based and free-standing ambulatory care, PPS-exempt hospitals, skilled nursing facilities, and home health agencies.

With respect to PPS, ProPAC would be required to recommend a hospital update factor as well as other proposed changes in current Medicare reimbursement systems to the Committees by March 1 of each year. In doing so, ProPAC would be directed to focus on major revisions to the DRG system including adjustments for severity, increasing the number of DRGs, and capital payment.

The Secretary would continue to be required to make an independent recommendation on the update by March 1. By May 1 of each year the Secretary would continue to be required to publish his revised recommendation for the update factor, as well as his recommendations for other changes in current reimbursement systems, in the *Federal Register*. If the Secretary's recommendations

were different from ProPAC's, the Secretary would be required to explain the reasons for the differences in the notice.

ProPAC would be required to report each year by June 1 on Medicare PPS and the health care system. ProPAC would report generally on issues and problems with the health care system as a whole and with hospitals and other institutional providers.

The Director's authority to appoint ProPAC Commissioners would be modified to clarify that the professions listed for membership of the Commission are illustrative, not determining. The Committee wishes to make clear that it does not expect the Director to assure that each and every category listed must be represented among the Commissioners at any given point in time.

The required OTA report to Congress would be eliminated. The requirement for the report to Congress on the Secretary's adjustments to PPS would be eliminated.

Effective Date

Hospital updates effective for discharges occurring on or after January 1, 1991. Changes in disproportionate share and increase in rural update (other than basic update) effective for discharges occurring on or after July 1, 1991. Extension of regional floor effective October 1, 1990. Changes in area wage index effective for discharges occurring on or after January 1, 1990. Technical correction on restandardization effective as if enacted as part of OBRA '89. Reporting requirements and swing bed reimbursement effective for cost reporting periods beginning on or after October 1, 1990. The repeal of physician offset effective as if enacted as part of OBRA '86. All other provisions effective upon the date of enactment.

Sec. 12003—Hospital DRG Payment Window

Present Law

In order to prevent unbundling of hospital services, all services provided to an inpatient of a hospital are paid through the DRG payment system, although the Secretary may waive this provision in certain isolated circumstances. Outpatient services may not be billed on behalf of an inpatient of a hospital. An inpatient stay is defined as beginning at midnight of the day of admission. The Medicare Intermediary Manual states further that services provided for up to 24 hours prior to the day of admission are considered to be part of the hospital stay and are not separately reimbursable under Part B of Medicare.

Explanation of Provision

In order to curb further unbundling which has occurred since the introduction of the DRG payment system, services provided on the day of admission and for up to 72 hours prior to the day of admission would not be separately reimbursable under Part B if Part A is the primary payer for the admission. Medicare carriers would be responsible for assuring that payment was not made under Part B for these services.

Effective Date

January 1, 1991.

*Sec. 12004—Payments for Graduate Medical Education**Explanation of Provision*

Medicare payments under Part A for the direct costs of graduate medical education (GME) are limited by provisions enacted in the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Payments to a hospital are based on the product of: (1) the approved amount per FTE resident for the hospital; (2) the number of FTE residents, and (3) the proportion of Medicare inpatient days. The share of GME payments from the Part A trust fund is determined by the Secretary and reflects the reasonable proportion of such costs of hospitals associated with the provision of services under Part A. The current allocation provides that 85 percent of GME payments are from the Part A trust fund.

The approved amount per FTE resident for a specific hospital is based on the hospital's individual costs for GME in the cost reporting period beginning on or after July 1, 1985. The approved amount per FTE resident in the base year is increased annually by the percentage change in the CPI-U.

The approved costs for each hospital include the salaries of residents and supervising physicians and other overhead costs directly attributable to the medical education program. The number of FTE residents used to calculate the approved amount per FTE resident is based on the number of FTE residents in the base year of 1985.

Residents beyond the initial period of residency are counted as .50 FTE. Residents in their initial years of residency are counted as 1.00 FTEs. Foreign medical school graduates are included in the FTE count only if they meet certain requirements.

Explanation of Provision

In determining the number of FTE residents for Medicare GME payments, each FTE resident beyond the initial three years of training in any specialty would be counted as 0.80 FTE. Each FTE resident in the initial period of training in specialties other than family medicine, internal medicine and pediatrics would be counted as 0.90 FTE. Each FTE resident in the initial period of training in internal medicine and pediatrics would be counted as 1.00 FTE.

Each FTE resident being specifically trained in primary care, as designated by the Secretary, would be counted as 1.10 FTE. Primary care specialties would be family medicine, general internal medicine and general pediatrics.

Positions in general internal medicine and general pediatrics would be designated by the Secretary as meeting criteria set by regulations following application by a hospital. In developing the criteria, the Secretary could adapt the criteria from the definitions developed for the primary care training assistance program under the Public Health Service Act.

The approved amount per FTE resident would be limited in each year to a set percent of the national median, adjusted for local wage and wage-related costs, of the hospital-specific approved FTE resident amounts. The limiting percentages would be 200 percent in fiscal year 1992, 175 percent in fiscal year 1993, and 150 percent in fiscal year 1994.

Effective Date

Effective for portions of cost reporting periods beginning on or after July 1, 1991.

Sec. 12005—PPS-Exempt Hospitals

Present Law

The reductions in capital-related payments does not currently apply to hospitals exempt from PPS.

Certain hospitals are exempt from the Prospective Payment System, including children's hospitals, psychiatric hospitals, rehabilitation hospitals, and long-term hospitals. These hospitals are paid based upon a hospital-specific target rate subject to a limit on the rate of increase.

The Secretary is directed to provide an exemption from, or an exception and adjustment to, a hospital's target rate if events beyond the hospital's control, or extraordinary circumstances, including changes in case mix and volume, or the closure of another hospital, cause a distortion in the hospital's costs. There are no time limits associated with the Secretary's authority. OBRA '89 required the Secretary to develop a process for hospitals to request exceptions and adjustments. Although the Secretary was required to develop such a process within six months of enactment, the Secretary has not developed the process at this time.

Among other remedies the Secretary may approve the use of a different base year for purposes of determining the appropriate target rate if the new base period is more representative of the reasonable and necessary cost of inpatient services.

Explanation of Provision

Capital-related costs for PPS-exempt hospitals would be reduced by 15 percent in FY '91 and '92.

The Secretary would be directed to develop a new prospective payment methodology for exempt hospitals or to modify substantially the current target rate system. The Secretary would be directed to report to the Committee on Ways and Means and the Committee on Finance his proposals to modify or replace the current system by February 1, 1991. The Prospective Payment Assessment Commission would be directed to report to the Congress with comments on the HHS proposal by May 1, 1991.

In developing the proposal to modify or replace the current system, the Secretary would be directed to consider: (1) Policies which provide for appropriate limits on growth in Medicare expenditures; (2) adjustments or other methodologies to account for changes in case mix, severity of illness, volume, technological development, necessary changes in medical practices; and (3) appropriate allocation of operating and capital costs to PPS-exempt units of hospitals and to general hospital operations.

In addition, the Secretary would be directed to consider the need for adjustments similar to those within the Prospective Payment System, including adjustments relating to disproportionate share of low-income patients, differential wage costs, teaching costs, and outliers.

The Committee wishes to make clear that modification of the current system may be a reasonable approach for the Secretary to propose, although development of a new system should not be ruled out in advance. However, if the Secretary chooses to continue the current target rate system, a number of concerns about the current system would need to be addressed. In particular the Committee is concerned that under a target rate system payments to hospitals over time may bear little relationship to the costs of providing services unless modifications to the base year are allowed, or unless automatic adjustments to the system are responsive to legitimate changes in the operation of the affected hospitals. The Committee would expect the Secretary's proposal to be responsive to these concerns.

The Contractor Performance and Evaluation standards would be amended to require fiscal intermediaries to evaluate and forward to the Health Care Financing Administration, with recommendations, applications from exempt hospitals for exceptions and adjustments to the target rates within sixty days of filing of a completed application, unless further information is required by the intermediary. If the application is not complete, the intermediary would be required to inform the applicant of what additional information was required within the sixty-day time period. HCFA would be required to act on applications within 120 days of receiving a completed application from the intermediary. HCFA would be required to provide guidance to the fiscal intermediaries and to hospitals on what a complete application should include within six months of enactment.

The grounds on which the Secretary may grant an appeal for an exception and adjustment to the TEFRA limits would be clarified. The grounds would include, but not be limited to: A change in applicable technology, medical practice, or case mix severity which increases costs above the target rate; or a change in wages and wage-related costs in the geographic area of the hospital in excess of the change nationally in wages paid by hospitals. If the Secretary does not approve an application, in whole or in part, he would be required to provide a detailed explanation of the grounds for his decision to the applicant hospital.

The Committee notes its continuing concern with the implementation of the requirements of subsection 101(c) of the Medicare Catastrophic Coverage Repeal Act regarding adjustments to the target amounts. Clause (2)(A)(ii) of the subsection requires the Secretary to adjust the target amounts to take into account costs related to beneficiaries who were inpatients of an excluded hospital and who had exhausted Medicare coverage prior to the period the MCCA was in effect. The Secretary's regulations published September 4, 1990, indicate the Secretary's willingness to grant adjustments to the target amounts as required by this provision. The Committee expects the Secretary to grant such adjustments expeditiously and without regard to whether the hospital incurred Medicare operating losses in the year MCCA was in effect.

Effective Date

Reduction of capital costs effective for cost reporting periods beginning on or after October 1, 1990. Development of a prospective

payment methodology and modifications to the CPEP standards effective upon the date of enactment. Modifications to appeal standards as if enacted in OBRA '89.

Secs. 12006—Freeze in Payments Under Part A through December 31, 1990

Present Law

Under current law payments to hospitals would be modified in several ways for fiscal year 1991. Payments would increase by the hospital market basket inflation index; new area wage indices would be effective; the regional floor would expire; and capital costs would be reimbursed at 100% of cost. Payments to hospices would increase by the market basket. Payments to skilled nursing facilities and home health agencies would not change.

Explanation of Provision

Payments to hospitals and hospices would be frozen at FY '90 levels. This would be accomplished by continuing the FY '90 standardized amounts, wage indices, and regional floor, and by continuing the FY '90 reduction in capital costs of fifteen percent. The update in payment for hospitals would be delayed to January 1, 1991.

Effective Date

November 1, 1990.

Subtitle B—Provisions Relating to Medicare Part B

PART 1—PAYMENTS FOR PHYSICIAN SERVICES

Secs. 12101–12104—Payments for Overprice Physician Services

Present Law

(a) **Overpriced Procedures**—OBRA '86 provided for a ten percent across the board reduction in the prevailing charges for cataract surgery. OBRA '87 provided for reductions in the prevailing charges of twelve procedures by two percent plus a sliding scale reduction ranging between zero and fifteen percent. The overpriced procedures were identified by the Physician Payment Review Commission (PhysPRC).

OBRA '89 provided for reductions in 244 overpriced procedures. Procedures were considered overpriced if the national average prevailing charge exceeded the amount that would be paid under the RB RVS by more than 10 percent, based on the recommendations of the PhysPRC. The reductions were equal to one-third of the amount that each procedure was overpriced in each locality, but not more than 15 percent, effective April 1, 1990. As written, this provision contains a technical drafting error that would lead to reductions of less than this amount.

The services considered by the Physician Payment Review Commission included only 379 codes of the 1,400 procedures studied in the first phase of the Harvard RB RVS study, and did not include any services not in the first phase of that study. Services not included represent about 27 percent of all physician services.

(b) **Payments for Radiology Services**—OBRA '87 established a fee schedule for radiology services based on a relative value scale. Payments for radiology services are based on the lesser of (1) actual charges and (2) a local conversion factor times the number of relative value units assigned to the professional and technical components of each procedure. The fee schedule applies to services provided by radiologists (board-certified or board-eligible radiologists, or to physicians for whom one-half of their Medicare charges are for radiology services). OBRA '87 set the radiology payments at 97 percent of the amount allowed under the fee schedule.

An additional reduction in the radiology payments of 4 percent, effective April 1, 1990 was included in OBRA '89. OBRA '89 also eliminated the January 1990 MEI update.

OBRA '89 also provided that most radiology services billed by other physicians could not exceed the payment that would be made under the radiology fee schedule.

All services reimbursed on a reasonable charge basis may be reduced by carriers if the carrier's usual payment in its private business is less than the amount that would otherwise be payable under Medicare.

When the radiology fee schedule was established in OBRA '87, the fees were to be established on the basis of carrier "service areas." This term has been used by the Secretary to mean carrier localities.

(c) **Payments for Anesthesia Services**—OBRA '87 provided for the development and establishment of an anesthesiology fee schedule based on a relative value scale for services rendered on or after January 1, 1989.

OBRA '89 specified that the time units used in computing the relative value units under the relative value schedule for both physicians and CRNAs would be based on the actual time, rather than rounded up to fifteen or thirty minute time units.

Anesthesiologists are reimbursed for the time they spend supervising anesthesia provided CRNAs. When supervising multiple concurrent procedures by CRNAs, the amount payable to the anesthesiologists for base units is reduced by 10% for two concurrent procedures, 25% for three concurrent procedures, and 40% for four concurrent procedures.

(d) **Pathology Services**—OBRA '87 provided for the development of a pathology fee schedule based on a relative value scale that could be used to pay for pathology services. The Secretary was required to submit a report to Congress on the pathology fee schedule. OBRA '89 provided that pathology services provided on or after January 1, 1991 would be paid based on the relative value scale developed by the Secretary.

Explanation of Proposal

(a) **Overpriced Procedures**—Procedures identified as overpriced in OBRA '89 would be reduced by the same amount as such procedures were reduced under OBRA '89. As OBRA '89 reduced the amount these procedures were overpriced by $\frac{1}{3}$, the reduction under this provision would reduce the amount these procedures are overpriced by an additional $\frac{1}{3}$, or $\frac{1}{2}$ of the remaining amount.

By making the same reductions as under OBRA '89, the reductions would reflect the same adjustments for differences in practice costs as under OBRA '89.

Services not included in the first phase of the Harvard RB RVS study, and not reviewed by the Physician Payment Review Commission, would have their prevailing charges reduced by 5 percent.

These procedures include all physician services except: (1) radiology, anesthesiology, pathology and overpriced procedures reduced by OBRA '89; (2) primary care services; (3) other so-called "evaluation and management" services including: hospital visits (HCPCS codes 90200 through 90292), consultations and second and third surgical opinions (HCPCS codes 90600 through 90654), preventive medicine visits (HCPCS codes 90750 through 90764), ophthalmology visits (HCPCS codes 92002-92014), other visits (HCPCS code 90699), psychiatric services (HCPCS codes 90801 through 90862), emergency care facility services (HCPCS codes 99062 through 99065), and critical care services (HCPCS codes 99160 through 99174); and (4) services reviewed by PhysPRC that are not considered overpriced by more than 10 percent or are under valued, including: partial, simple, and subcutaneous mastectomy (HCPCS codes 19160 through 19182), tendon sheath injections and small joint arthrocentesis (HCPCS codes 20550 through 20610), femoral fracture and trochanteric fracture treatments (HCPCS codes 27230 through 27248), endotracheal intubation (HCPCS code 31500), thoracentesis (HCPCS code 32000), thoracostomy (HCPCS codes 32020 through 32036), lobectomy (HCPCS codes 32485 and 32490), aneurysm repair (HCPCS codes 35022 and 35111), enterectomy (HCPCS code 44125), colectomy (HCPCS code 44151), cholecystectomy (HCPCS code 47612), cystourethroscopy (HCPCS code 52340), transurethral fulguration and resection (HCPCS codes 52606 and 52620), sacral laminectomy (HCPCS code 63011), tympanoplasty with mastoidectomy (HCPCS codes 69643 and 69645), and ophthalmoscopy (HCPCS codes 92225, 92250 and 92260).

In addition, the drafting error in the calculation of reductions in overpriced provided for in OBRA '89 would be corrected.

(b) Payments for Radiology Services—The local conversion factors used for payments under the radiology fee schedule would be reduced by up to fifteen percent. The amount of the reduction in each locality would be calculated as follows: (1) the national average conversion factor that applied after April 1, 1990 would be reduced by six percent; (2) a local reduced conversion factor amount would be estimated by adjusting the overhead and work components of the reduced national average conversion factor by a GPCI and physician work geographic index in the same manner as under the RB RVS; and (3) the local conversion factor would be reduced to the adjusted local amount, up to a maximum reduction of fifteen percent. If the local conversion factor was less than the adjusted local amount, the local conversion factor would not be changed.

In applying the GPCI and physician work geographic adjustments, the Secretary would provide that 80 percent of the professional component and 35 percent of the technical component of radiology fees represents physician work.

The GPCI and work adjustments used in calculating the local reduced conversion factor would be the most recent estimates of the adjustments that would apply under the RB RVS.

The prevailing charges of radiology services not reimbursed under the fee schedule would be reduced to the fee schedule amount.

The relative values under the radiology fee schedule for CAT scans and MRI scans would be reduced by 10 percent. The Committee intends that, while so-called "PET" scans are not currently covered under Medicare, if and when the Secretary determines that payments should be made for this service, the relative values for these services should reflect this 10 percent reduction in relative values for MRI and CAT scans.

Carriers would be prohibited from applying the comparable fee rule to services under the radiology fee schedule, effective with implementation of the RB RVS on January 1, 1992.

Payments under the radiology fee schedule would be differentiated by payment "localities" as opposed to carrier "service areas". This provision would make the payment areas for radiology services consistent with the payment areas for other physician services, and with the payment areas under the RB RVS. This would be effective as if included in OBRA '87.

(c) Payments for Anesthesia Services—The local conversion factors used for payments for physician anesthesia services would be reduced by up to fifteen percent. The amount of the reduction in each locality would be calculated as follows: (1) the national average conversion factor that applied after April 1, 1990 would be reduced by six percent; (2) a local reduced conversion factor amount would be estimated by adjusting the overhead and work components of the reduced national average conversion factor by a GPCI and physician work geographic index in the same manner as under the RB RVS; and (3) the local conversion factor would be reduced to the adjusted local amount, up to a maximum reduction of fifteen percent. If the local conversion factor was less than the adjusted local amount, the local conversion factor would not be changed.

In applying the GPCI and physician work geographic adjustments, the Secretary would provide that 70 percent of fee represents physician work.

The reduction in payments to anesthesiologists for supervising multiple concurrent services by CRNAs would be extended through December 31, 1995.

Carriers would be prohibited from applying the comparable fee rule to anesthesia services, effective January 1, 1992.

(d) Pathology Services—Payments for pathology services would be reduced by 6 percent.

The requirement to implement the pathology fee schedule on January 1, 1991 would be repealed. Pathology services would be paid under the RB RVS beginning January 1, 1992. The requirement for the Secretary to submit a report to Congress on the pathology fee schedule would be repealed.

Effective Date

Subsections (a) is effective on January 1, 1991, except for the paragraph relating to an OBRA '89 technical correction which is

effective as if included in OBRA '89, subsection (b) is effective on January 1, 1991, except for the paragraph relating to payment localities which is effective as if included in OBRA '87; subsections (c) and (d) are effective for services provided on or after January 1, 1991.

Sec. 12105—Payments for Physician Services

Present Law

Customary and prevailing charge screens, fee schedules and limits on actual charges are scheduled to be updated on January 1 of each year. In general, prevailing charges are updated by the percentage change in the Medicare Economic Index (MEI).

OBRA '89 delayed the annual update to April 1, 1990. Primary care services were updated by 4.2 percent, the full amount of the MEI. The update for other services was two percent, except for radiology, anesthesiology, and services identified in OBRA '89 as overpriced which were not updated.

The prevailing charges for primary care services are subject to a lower limit equal to 50 percent of the national average prevailing charge for participating physicians for such services.

For all physician services, the transition to the RB RVS in 1992 is based on an amount known as the "historical payment basis." This is defined as the weighted average prevailing charge applied in the locality in 1991, adjusted to reflect payments for services at amounts below the prevailing charge. The historical payment basis is determined without regard to physician specialty.

The Physician Payment Review Commission (PhysPRC) was established in COBRA. Since it was established, the primary responsibility of the Commission has been the development of a physician payment reform proposal. Congress enacted payment reform in OBRA '89. Current law provides that the Commission's membership includes a variety of health professionals, researchers and representatives of consumers and the elderly.

OBRA '89 established a system of Medicare Volume Performance Standards (MVPS) which is used for calculating the annual update in fees for physician and certain other Part B services on or after January 1, 1992.

Under this system, Congress would enact specific levels of increases in expenditures for a subsequent calendar year for surgical services, non-surgical services and overall physician services.

In the absence of Congressional action, the rate of increase in expenditures is determined by a formula specified in law. The formula sets the allowed increase in expenditures under the MVPS equal to the sum of: (1) the percentage increase in fees; (2) the increase in number of Part B enrollees, excluding HMO risk-contracting enrollees; (3) an estimate of the historical rate of increase in volume of services; (4) any change in expected payments due to legislation or regulations; and (5) reduced by an amount equal to 0.5 percent for the year 1990, 1 percent for 1991, 1.5 percent for 1992, and 2 percent thereafter.

The update for the second calendar year beginning after the close of the year for which a volume performance standard is set is equal the MEI, adjusted by the amount by which expenditures

exceed or are under the standard, subject to certain limits specified in law.

Explanation of Proposal

The update for all reasonable charge fee screens and fee schedules would be equal to the MEI for primary care services, and 0 percent for all other services.

The MEI that would apply on January 1, 1992 would be reduced by 0.4 percent from the amount that would otherwise apply. The Committee intends that this would result in an update of 2 percent in 1992.

The lower limit on prevailing charges for primary care services would be set at 75 percent of the national average prevailing charge for primary care services rendered during calendar year 1991.

For the purpose of determining the fees after 1991 for primary care services adjusted by the 75 percent lower limit, the historical payment basis would be determined without regard to the adjustment to 75 percent in the lower limit. However, fees for services whose payments had been changed by this adjusted limit in 1991 could not be lower in 1992 than they were in 1991 after the adjustment.

Provisions relating to the development of a physician payment reform package by PhysPRC and the Secretary would be repealed. Provisions relating to the outdated usual and customary payment system would be repealed. The requirement that PhysPRC advise the Secretary on the development of the RB RVS would be repealed.

The current provision requiring PhysPRC to consider policies under Medicare would be amended to include consideration of (1) major issues in the implementation of the RB RVS; (2) Issues relating to further development of the volume performance standard system, including continuing development of State-based programs and other approaches; (3) payment incentives to increase access to primary care and other services in inner-city and rural areas, including Federal policies regarding the level of Medicaid payments to physicians; (4) the number and types of physicians being trained, including consideration of Medicare graduate medical education policy; (5) issues relating to utilization review and quality of care, including revisions to the PRO and other Medicare quality assurance programs, and physician licensing and certification; and (6) options to help constrain the costs of health care to employers, including incentives under Medicare. In addition, PhysPRC would be required to make recommendations regarding reforms in medical malpractice and physician licensing and certification.

Current law would be clarified to indicate that the professions listed for membership are illustrative.

The MVPSPs for surgical services, non-surgical services, and overall, would be set by a formula equal to the sum of the percentage growth in the number of Part B enrollees (excluding HMO enrollees), the historical percentage growth in volume, and the percentage change in expected expenditures due to provisions included in this bill and any regulations issued by the Department which

would effect the growth in expenditures for services covered by the MVPS system, minus an adjustment factor.

The historical rates of growth in volume and growth in number of beneficiaries used in calculating these standards would be the same for surgical, nonsurgical, and overall categories of services. The adjustment factor would be -1 percent in 1991, -1.5 percent in 1992, -2.0 percent in 1993, 1994 and 1995.

The component reflecting changes in expenditures due to provisions included in this bill, effecting either levels of fees or services provided, would vary between surgical and nonsurgical categories by the relative impact of this bill on expenditures for these two categories of services.

Current CBO estimates of the historical rate of growth in volume are 7.3 percent each fiscal year from 1991 through 1995. Estimated changes in number of Part B enrollees are 1.2 percent in fiscal year 1991, 1.1 percent in 1992, 1.0 percent in 1993, and 1.1 percent in 1994 and 1995.

The estimated overall impact of provisions included in this bill would allow for an increase in expenditures of 1.1 percent in fiscal year 1991, 2.1 percent in 1992, 2.8 percent in 1993, and 2.7 percent in 1994 and 1995.

Under these estimates, the overall MVPS would be 8.5 percent for fiscal year 1991, 9.0 percent for 1992, 9.1 percent for 1993, and 11.1 percent for 1994 and 1995. The surgical and nonsurgical MVPS standards would vary from this estimate only to reflect the relative impact of this bill, and regulations that may be issued by the Department, on expenditures for services within each category.

The Committee intends that the final determination of the MVPS standards would be adjusted to reflect the final estimates and distribution of savings resulting from this bill.

Effective Date

Effective for services provided on or after January 1, 1991, except for the paragraphs relating to PhysPRC which would be effective on enactment.

Secs. 12106-12108—Other Provisions Relating to Physician Services

Present Law

(a) New Physicians—OBRA '87 provided that the customary charge screens of new physicians are set at a level no higher than eighty percent of the prevailing charge, as limited by the MEI, for the first year the physician is practicing in an area.

OBRA '89 provided that in the second year of practice, a new physician's customary charge is limited to 85 percent of the prevailing amount. The limit does not apply to primary care services or to services furnished in a rural health manpower shortage area.

These limits expire on December 31, 1990.

(b) Assistants at Surgery—Under certain circumstances, physicians are paid for serving as assistants at surgery. Typically, the prevailing charge for acting as an assistant is limited to 20 percent of the prevailing charge of the procedure that applies to the primary surgeon.

(c) Interpretation of EKGs—Payments are not made for the interpretation of simple diagnostic tests. The payment for the interpretation is presumed to be part of the services included within the payment for an office or hospital visit. EKGs are an exception to this rule, and separate payments are currently made for the interpretation of EKGs.

Explanation of Proposal

(a) New Physicians—The customary charges of new physicians in 1991 would be limited to 80/85/90/95 percent in the first through fourth years of practice. Beginning on January 1, 1992, these percentage limits for new physicians in their first through fourth years of practice would apply to the amounts recognized under the RB RVS.

(b) Payments for Assistant at Surgery Services—Physicians acting as an assistant at surgery for a procedure that routinely involves the use of an assistant would be paid under current policy. A procedure would be considered as routinely involving the use of an assistant if an assistant is used in 50 percent or more of such cases nationwide.

When a procedure has a variable use of an assistant, the fee for the assistant would be reduced to 15 percent of the prevailing charge. Procedures would be considered to have variable use of an assistant if an assistant is used in fewer than 50 percent and 25 percent or more of such cases nationwide.

If a procedure infrequently requires use of an assistant, the fee for the assistant would be reduced to 15 percent of the prevailing charge for the procedure, and the primary surgeon would have to obtain prior authorization for the assistant from a PRO. Procedures would be considered to have an infrequent use of an assistant if an assistant is used in less than 25 percent and 5 percent or more of such cases.

Payments would not be made for an assistant at surgery if an assistant is used in fewer than 5 percent of cases.

The Secretary would categorize procedures by their percentage of use of an assistant using the most recent data available.

(c) Interpretation of EKGs—Payments for the interpretations of EKGs would be treated the same as other simple diagnostic tests under the RB RVS, effective 1/1/92. That is, the interpretation would be considered to be part of an office or hospital visit. The provision would be effective on January 1, 1992, after the increase in payments for office and hospital visits are made under the RB RVS.

Separate payments would not be made for interpretation of EKGs, as under current policy for laboratory tests, except when the EKG is not performed in conjunction with an office or hospital visit. Payments would continue to be made for the technical component of EKGs on an outpatient basis.

Payments for EKG interpretations performed in conjunction with an office visit, or for inpatients, would be excluded from the expenditure base used in determining the initial budget neutral conversion factor for the RB RVS.

Effective Date

Subsections (a) and (b) would be effective for services provided on or after January 1, 1991; subsection (c) would be effective on January 1, 1992.

PART 2—PAYMENTS FOR OTHER SERVICES*Sec. 12111—Payments for Hospital Outpatient Services**Present Law*

(a) Capital—For hospital outpatient department services which are paid either on a reasonable cost basis or the lesser of reasonable costs and a blend of reasonable costs and charges, Medicare paid for hospital capital allocated to the outpatient department of the hospital at 100 percent of costs prior to fiscal year 1990.

OBRA '89 reduced payments for capital costs for outpatient services by 15 percent for portions of cost reporting periods in fiscal year 1990. The reduction also applied to capital related to services that are reimbursed based on a blended amount (x-ray services and outpatient surgical services). In the case of such blends or limited based on blends, the reduction applied only to the cost portion of the blended amount.

Outpatient capital costs of sole community hospitals were exempt from the reduction in OBRA '89.

(b) Outpatient Services on a Cost Related Basis—Services in hospital outpatient departments are reimbursed under a variety of payment methodologies. Laboratory services and durable medical equipment are paid based on fee schedules; outpatient dialysis services are paid based on a prospective rate. Ambulatory surgical services and radiology services are subject to aggregate cost limits, based on a blend of the hospital's costs and the costs for similar services provided outside of the hospital setting. Most other services are paid on a cost related basis.

(c) Payments for Ambulatory Surgery and Radiology.—Ambulatory surgical services and radiology services are subject to aggregate cost limits. The limits are based on a 50/50 blend of the hospital's own costs, and the fees for the same services provided outside of the hospital setting.

Payments to an eye, or eye and ear specialty hospital for ambulatory surgery are subject to a limit based on a special blend of 75 percent of the hospital's costs and 25 percent of the applicable free-standing ambulatory surgical center rate. This blend is effective for portions of cost reporting periods that begin prior to the end of fiscal year 1990.

Payments for intraocular lenses (IOLs) are included in the facility fees for free-standing ambulatory surgical centers. The current rates reflect an allowance of \$200 per lens.

(d) Graduate Medical Education—Payments for Graduate Medical Education—Medicare payments under Part B for the direct costs of graduate medical education (GME) are limited by provisions enacted in the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Payments to a hospital are based on the product of: (1) the approved amount per FTE resident for the hospital; (2) the number of FTE residents; and (3) the proportion of Medicare inpa-

tient days. The share of GME payments from the Part B trust fund are determined by the Secretary and reflects the reasonable proportion of such costs of hospitals associated with the provision of services under Part B. The current allocation provides that 15 percent of GME payments are from the Part B trust fund.

The approved amount per FTE resident for a specific hospital is based on the hospital's individual costs for GME in the cost reporting period beginning on or after July 1, 1985. The approved amount per FTE resident in the base year is increased annually by the percentage change in the CPI-U.

The approved costs for each hospital include the salaries of residents and supervising physicians and other overhead costs directly attributable to the medical education program. The number of FTE residents used to calculate the approved amount per FTE residents is based on the number of FTE residents in the base year of 1985.

Residents beyond the initial period of residency are counted as .50 FTE. Residents in their initial years of residency are counted as 1.00 FTEs. Foreign medical school graduates are included in the FTE count only if they meet certain requirements.

Explanation of Proposal

(a) Capital—Medicare would pay for capital allocated to hospital outpatient departments on the same basis as capital for inpatient services under Part A; that is, at 85 percent of costs. When payments for hospital outpatient department services are paid subject to blended limits, the cost portion of the blend would include allocated capital at the reduced percentage.

Sole community hospitals and so-called EACH and RPDH hospitals would be exempt from this reduction.

(b) Outpatient Services on a Cost Related Basis—Payments for services that are on a cost related basis would be reimbursed at 98 percent of the recognized costs. This reduction would also apply to the cost portions of blended payment limits for ambulatory surgery and radiology services.

Sole community hospitals and so-called EACH and RPDH hospitals would be exempt from this reduction.

The Secretary would provide for the development of a proposal for paying for hospital outpatient services under a prospective payment system. In developing this proposal, the Secretary would consider: (1) policies which provide for appropriate limits on growth in expenditures; (2) adjustments to account for changes in types of patients treated, volume, technology, and medical practice; (3) incentives for hospitals to control costs; (4) appropriate bundling of services, such as global fees or per episode units of payment; (5) whether services not currently paid on a cost related basis, such as outpatient dialysis and laboratory services, should be included in the new system; and (6) whether other adjustments would be necessary, including adjustments for teaching status, geographic area, treatment of low-income patients, and capital.

In developing the prospective payment system, the Secretary would consider whether payments for the same service should vary by the type of facility in which the service is provided, such as between free-standing facilities and hospital based outpatient departments.

The Committee intends that, in considering the impact of new technology on the cost of outpatient services, the Secretary would pay particular attention to issues raised by the impact of new technologies on the costs of IOLs, including whether additional payments or special adjustments are warranted for so-called "high technology lenses."

The Administrator of the Health Care Financing Administration would provide the Committees with summaries of existing research findings by January 1, 1991. The Secretary would submit a detailed proposal to the Committees by September 1, 1991.

The Prospective Payment Assessment Commission would submit a report on prospective payments for hospital outpatient services, including comments on the Secretary's proposal, by March 1, 1992.

(c) Payments for Ambulatory Surgery and Radiology—Ambulatory surgical services and radiology services in hospital outpatient departments would be subject to aggregate cost limits based on a 33/67 blend of the hospital's own costs, and the fees for the same services provided outside of the hospital setting, effective January 1, 1991.

Use of the special limit based on the 75/25 blend for ambulatory surgery provided in eye and eye and ear specialty hospitals would be extended to services provided in cost reporting periods that begin in fiscal years 1991 through 1995.

In determining the payment rates for free-standing ambulatory surgical facilities, the Secretary would recognize an allowance of \$200 per IOL, effective on enactment through December 31, 1992.

(d) Graduate Medical Education—In determining the number of FTE residents for Medicare GME payments, each FTE resident beyond the initial three years of training in any specialty would be counted as 0.80 FTE. Each FTE resident in the initial period of training in specialties other than family medicine, internal medicine and pediatrics would be counted as 0.90 FTE. Each FTE resident in the initial period of training in internal medicine and pediatrics would be counted as 1.00 FTE.

Each FTE resident being specifically trained in primary care, as designated by the Secretary, would be counted as 1.10 FTE. Primary care specialties would be family medicine, general internal medicine and general pediatrics.

Positions in general internal medicine and general pediatrics would be designated by the Secretary as meeting criteria set by regulations following application by a hospital. In developing the criteria, the Secretary could adapt the criteria from the definitions developed for the primary care training assistance program under the Public Health Service Act.

The approved amount per FTE resident would be limited in each year to a set percent of the national median, adjusted for local costs, of the hospital specific approved FTE resident amounts. The limiting percentages would be 200 percent in fiscal year 1992, 175 percent in fiscal year 1993, and 150 percent in fiscal year 1994.

The current statutory language would be amended to clarify the distinction in payments between the Part A and Part B trust funds.

Effective Date

Subsections (a) and (b) apply to payments for portions of hospital cost-reporting periods beginning on or after October 1, 1990 and ending December 31, 1993, except for the paragraphs relating to prospective payment for outpatient services which would be effective on enactment; subsection (c) applies to portions of cost-reporting periods beginning on or after January 1, 1991, except for the paragraph relating to the special blend for eye and eye and ear specialty hospitals which would be extended through December 31, 1995, and the paragraph relating to payments for IOLs which would be effective on enactment through December 31, 1992; subsection (d) applies to payments for graduate medical education related to portions of cost reporting periods on or after July 1, 1991.

Sec. 12112—Durable Medical Equipment

Present Law

(a) **Overpriced and Overutilized Equipment**—OBRA '89 reduced the fee schedule amounts for seatlift chairs and transcutaneous electrical nerve stimulation (TENS) devices by fifteen percent, effective April 1, 1990.

The Secretary is authorized to require that, prior to delivery of certain items, the supplier must have a written order for the item from a physician.

(b) **Limits on Variations in Fees**—Current law provides for transition to a system of regional fees for three categories of DME by 1993. The categories are orthotics and prosthetics, rental-cap items, and oxygen and oxygen equipment. The regional fees would be based on a weighted average of local and regional payment amounts within each region, subject to certain upper and lower limits. Payments in 1990 are based solely on the local amounts; payments in 1993 would be based solely on the regional amounts. 1991 and 1992 would be transition years between the two amounts.

(c) **Rental Items**—OBRA '87 defined six categories of DME and established fee schedules for each category. Payment for items in the category of "other items of DME," often referred to as the "rental cap" category, is only on a rental basis. Items in this category include wheel chairs and hospital beds. The rental payment amount in 1989 and 1990 is ten percent of the purchase price of the item based on average submitted charges during a twelve month base period ending June 30, 1987, and updated by the percent increase in the Consumer Price Index (CPI-U) for the six month period ending December, 1987. Rental payments are made for up to fifteen months, after which a payment, equal to one month's rental, is made every six months for servicing.

OBRA '89 removed motorized wheelchairs from the "rental cap" category into the "frequently purchased" category with a provision allowing for treatment of such wheelchairs as customized equipment, subject to guidelines to be established by the Secretary.

There is currently no provision for the replacement, and for a new cycle of rental payments, of items provided under the rental cap category.

(d) **Oxygen Retesting**—In order to qualify for Medicare's oxygen benefit, beneficiaries must have the medical necessity for oxygen

therapy demonstrated by a laboratory test. There are currently no requirements for retesting patients who may need oxygen on a long term basis.

(e) Update for DME—Current law provides that the fee schedule amounts for DME are updated annually by the CPI-U. Under OBRA '89 the fees for these items and services were not updated in 1990.

(f) Enteral and Parenteral Equipment and Supplies—Nutritional supplies for enteral equipment are reimbursed on a reasonable charge basis. The payment amounts for these services are updated by the CPI-U.

(g) Orthotics and Prosthetics—Orthotics and prosthetics are one of the six categories of durable medical equipment defined by OBRA '87. Under current law, these fees are updated annually by the CPI-U, and would move to regional rates by 1993.

Explanation of Proposal

(a) Overpriced and Overutilized Equipment—The fee schedule amounts for seatlift chairs and TENS devices would be reduced by fifteen percent.

Suppliers would be prohibited from distributing completed or partially completed Medicare medical necessity forms for commercial purposes, including patients. Suppliers would distribute such forms would be subject to civil monetary penalties up to \$1,000 per form distributed.

For customized equipment and for equipment designated by the Secretary as requiring a prior written physician's order, suppliers could request prior approval of the item from a carrier in a form determined by the Secretary. The Secretary would establish standards for the timeliness of carrier responses to such requests, and would incorporate such standards into the evaluations of carriers' performance.

Claims for item of DME that are potentially overused would be subject to special carrier scrutiny. The Secretary would publish, and periodically update, a list of such items. The list would include: seatlift chairs, TENS equipment, power-driven scooters, and such other items of DME as determined appropriate by the Secretary. The Secretary would include items that are: (1) mass marketed directly to beneficiaries; (2) marketed with offers to waive the coinsurance, or marketed as "free" or "at no cost" to beneficiaries with Medigap coverage or other coverage; (3) subject to a consistent pattern of overutilization; and (4) frequently denied based on a lack of medical necessity.

The Committee intends that such "special carrier scrutiny" may entail requiring additional information from the supplier or ordering physician including: the name of the patient's regular physician, the medical condition being treated, the course of recommended treatment, and the relationship between the prescribing physician and supplier, if any.

(b) Limits on Variations in Fees—The requirements relating to regional fees would be repealed, except for orthotics and prosthetics as described in subsection (k) below. National upper and lower fee limits would be established, and local fees above or below these limits would be phased to the limiting amount in 1993.

The national upper limits for an item would be defined as the weighted average of the fee schedule amounts that apply in 1991, weighted by the frequency that each item is provided in each locality. The upper limits would be updated annually. In 1991 and 1992, payments would be capped by a blend of the local fee schedule amount and the national limit. In 1991, the blend would be based on 67 percent of the local fee and 33 percent of the national limit. In 1992, the blend would be based on 33 percent of the local fee and 67 percent of the national limit. In 1993, the fee schedule amounts in areas that exceed the upper limit would be set at the national limit.

National fee "floors" for an item would be defined as 85 percent of the national upper limits in 1991. The fee floors would be updated annually. In 1991 and 1992, payments would be subject to a lower limit equal to a blend of the local fee schedule amount and the national fee floor. In 1991, the blend would be based on 67 percent of the local fee and 33 percent of the national floor. In 1992, the blend would be based on 33 percent of the local fee and 67 percent of the national floor. In 1993, the fee schedule amounts in areas that are below the national floor would be set at the floor.

Fees in areas that are between the average and 85 percent of the average would not be effected by this provision.

The limits on fees would apply to all categories of DME except for customized equipment that are paid on a reasonable charge basis, and orthotics and prosthetics are provided below.

(c) Rental Items—The fee schedules for rental cap items would be based on average allowed charges, rather than average submitted charges, during the base period. The Secretary would be permitted to implement this policy as an across the board reduction in payments for items in this category. The percentage reduction would reflect the average difference between submitted and allowed charges in the base period.

Rental payments for "rental cap" items would be based on ten percent of the recognized purchase price for the first three months of rental, and 7.5 percent of the recognized purchase price during the fourth through fifteenth months of rental. No rental payments would be made after the fifteenth month.

In the tenth month of continuous rental, patients would be given the option to purchase the item of equipment. If the patient elects this option, rental payments would continue through the thirteenth month of rental when ownership of the item would transfer to the patient. No additional rental payments would be made. For items owned by patients, payments for servicing would be based on reasonable charges.

In addition, items in this category may be obtained on either a rental or lump-sum purchase basis, when provided as a replacement item after the useful lifetime of the equipment has passed, as described under subsection (e), below.

If the patient declines a purchase option, either for rental items or replacement items, payments for servicing would be as provided under current law, with a limit equal to 10 percent of the recognized purchase price.

Non-customized motorized wheelchairs would be recategorized back into the rental cap category of equipment. The option for treating wheelchairs as customized would not be changed.

If the Secretary does not issue regulations defining "customized" wheelchairs by January 1, 1992, a statutory definition would become effective. Under this definition, a customized power driven or manual wheelchair would be defined as a wheelchair which has been: (1) measured, fitted, or adapted in consideration of a patient's body size, disability, length of need or intended use; and (2) has been assembled by the supplier or ordered through a manufacturer who make available customized features, modifications or components that are intended for a specific patient's use in accordance with a physician's order.

In applying this definition, the Committee intends that examples of features that are only available in customized equipment may include, but are not limited to: (1) semi or full reclining backs, (2) special heights for arms, seats or backs, (3) special width or depth of seat, (4) attachments to convert wheelchairs to one-armed drive, (5) postural control devices, (6) custom molded cushions and inserts, or lateral supports.

This definition would become effective on January 1, 1992, unless the Secretary provides for an alternative definition of customized wheelchairs prior to January 1, 1992, in which case the provision would not be effective.

The Secretary would establish a reasonable useful lifetime of rental equipment, including frequently serviced items. The useful lifetime would be 5 years, unless the Secretary finds, based on program experience, that a longer or shorter period is appropriate for an item. After an item's useful lifetime is reached during a continuous period of medical necessity, the Secretary would provide for a new cycle of rental payments.

Carriers would be permitted to make exceptions, and begin a new cycle of rental payments, for equipment that is lost or irreparably damaged. Such exceptions would only be authorized after special consideration and scrutiny of the circumstances by the carrier.

(d) Oxygen Retesting—Beneficiaries that qualify for oxygen therapy for an initial period not exceeding 3 months would be retested to confirm their continued need for oxygen use, prior to continuing payments for oxygen therapy beyond the initial 3 months. Patients receiving oxygen therapy prior to the effective date of this proposal would not be subject to the retesting requirement. The Secretary would consult with the industry in implementing this provision, and would permit oxygen suppliers to manage the oxygen retesting process.

(e) Update for DME—The update for DME items and services would be reduced by 1 percent for calendar years 1991 and 1992.

(f) Enteral and Parenteral Equipment and Supplies—The update of fees for enteral and parenteral equipment and supplies would be reduced to 0 percent for 1991.

(g) Orthotics and Prosthetics—Payments for orthotics and prosthetics would be recodified in a separate subsection of law. The current requirements relating to regional fees would be delayed by one year. Otherwise, payments would be made on the same basis as

under current law. The one-year delay in regional rates would permit HCFA to review the fee schedule for these services and make appropriate corrections.

The update for orthotic and prosthetic fees would be reduced to 0 percent for 1991.

The GAO would conduct a study of payments for orthotic and prosthetic items and services under Medicare. This study would examine how the combination of fees from different types of professionals and providers, including fees of physicians, DME suppliers, physical therapists, and others, effected the amounts paid to orthotists and prosthetists for these services. The GAO would submit a report to the House Ways and Means and Energy and Commerce Committees and the Senate Finance Committee within 18 months of enactment. The Comptroller General would include in such report any recommendations he deems appropriate.

Effective Date

Effective for services provided on or after January 1, 1991, except for the paragraphs relating to the GAO study in subsectioni (g) which would be effective on enactment.

Sec. 12113—Clinical Laboratory Services

Present Law

(a) **Laboratory Fee Schedule Update**—The laboratory fee schedules are generally updated each January 1 by the annual percentage change in the CPI-U over the preceding year.

(b) **Payments for Laboratory Services**—The local laboratory fee schedules are subject to national ceilings. These ceilings are based on the median of all carrier-wide fee schedules established for that test in that laboratory setting.

OBRA '89 reduced the cap from 100 to 93 percent of the national median and repealed the requirement that payments for these services would be based on a national fee schedule.

In general, clinical laboratory tests are only reimbursed on an assigned basis. Since 1988, physicians have been prohibited from billing patients for such tests on an unassigned basis. A recent decision in the U.S. 6th Circuit Court of Appeals indicated that there may be some ambiguity as to whether the assignment requirement applies to such tests performed in all physician offices.

Explanation of Proposal

(a) **Laboratory Fee Schedule Update**—The update for the laboratory fee schedule would be reduced by 2 percent for 1991, 1992, and 1993.

(b) **Payments for Laboratory Services**—The national cap would be reduced to 88 percent of the median, effective January 1, 1991.

Current statutory language would be clarified to provide that all clinical laboratory tests provided in all settings, including physician offices, could only be billed on an assigned basis.

Effective Date

Subsections (a) and (b) apply to services provided on or after January 1, 1991, except for the paragraph relating to assignment

which is effective as if included in the Consolidated Omnibus Reconciliation Act of 1985.

Sec. 12114—Reduction of Payments under Part B Through December 31, 1990

Present Law

Under the Balanced Budget and Emergency Deficit Control Act of 1985, Medicare payments may be reduced by up to 2 percent pursuant to a sequester order by the President. The actual reduction applies to payments for services rendered on or after October 15 of a fiscal year. To obtain a 2 percent savings from the entire fiscal year, the actual percent reduction would be 2.034 percent to account for services provided prior to October 15 that would not be reduced.

Such an order was issued by the President with respect to fiscal year 1990 on October 15, 1989. OBRA '89 permitted this reduction to remain in effect for services under Part B through March 31, 1990. In addition, OBRA '89 provided for a reduction of 1.4 percent that applied to services provided during the last six months of fiscal year 1990.

When payments are reduced under a sequester, patient liability for deductible and coinsurance amounts are unchanged.

Explanation of Proposal

Medicare payments to physician, providers and suppliers under Part B, other than payments to risk-contracting HMOs, would be reduced by 2 percent for the two month period beginning November 1, 1990.

Beneficiary liability for deductible and coinsurance amounts would not be affected by this reduction, in the same manner as they are not effected under a sequester order.

Effective Date

Applies to services provided on or after November 1, 1990 and prior to January 1, 1991.

Subtitle C—Provisions Relating to Medicare Parts A and B

Sec. 12201—End Stage Renal Disease Services

Present Law

Hospital and free-standing facilities are paid a composite rate that takes into account the proportion of patients dialyzing at home. Under the composite rate, the average base payment is \$125 per treatment in free-standing facilities and \$129 per treatment in hospital units.

The Omnibus Budget Reconciliation Act of 1989 required the Secretary to maintain the composite rate through October 1, 1990 and required the Secretary to follow prescribed regulatory procedures before revising the composite rates in effect on September 30, 1990.

Medicare currently provides coverage for erythropoietin for renal dialysis patients if the drug is not self-administered. Payment is made in the form of an add-on to a facility's composite rate.

The Health Care Financing Administration (HCFA) established a rate of \$40 per treatment for dosages under 10,000 units and \$70 for dosages of 10,000 units and above. HCFA's payment rate was based upon average dose levels of 5,000 units. More recent data indicate that average dose levels have dropped to 2,700 units per treatment.

The Medicare program pays eighty percent of the rate, while beneficiaries are responsible for the remaining 20 percent. Facilities and physicians are prohibited from billing the beneficiary for additional amounts.

Explanation of Provision

The Secretary would be required to establish a rate for hospital and free-standing facilities not less than the rate in effect September 30, 1990 had the rate not been subject to the reduction in payments under Part B as required under section 6101 of OBRA '89. This provision would expire December 31, 1995.

The Secretary would be directed to revise payments for erythropoietin. Payments would be based upon 1,000 unit increments. The Secretary would make payments of no more than \$11.00 per 1,000 units up to a maximum payment of \$70 per dose. Beginning in FY 92, the payment level for erythropoietin would be indexed to the GNP deflator. The Secretary would continue to make payments as an add-on to the composite rate.

Effective Date

Provisions pertaining to the current composite rate would take effect as if included in the enactment of OBRA '86. Provisions pertaining to payments for erythropoietin would be effective for erythropoietin provided on or after January 1, 1991.

Sec. 12202—Medicare Secondary Payer

Present Law

(a) Identification of Medicare Secondary Payer Situations—Medicare is a secondary payer under specified circumstances when individuals are covered by other third party payers. Medicare is secondary payer to automobile, medical, no-fault and liability insurance, and to employer health plans.

Medicare is secondary payer to certain employer health plans for aged and disabled beneficiaries. Medicare is also secondary payer to employer group health plans for items and services provided to end stage renal disease (ESRD) beneficiaries during the first 12 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

The Department of Health and Human Services (HHS) currently identifies Medicare secondary payer cases in the following ways: beneficiary questionnaires, provider identification of third party coverage when services are provided, and data transfers with other Federal and State agencies.

In addition, as a result of changes made in the OBRA '89, HHS is able to use data provided by the Social Security Administration and the Internal Revenue Service to improve identification and collection of Medicare secondary payer cases. This information is par-

ticularly useful for identifying spouses of beneficiaries who may be covered by an employer health plan.

HHS's contractors use this new information to contact employers in writing to determine whether the employer provided health coverage and the date of such coverage. Current restrictions on the disclosure of information under the Internal Revenue Code and the Privacy Act also apply to the new information provided by SSA and IRS to HCFA.

This provision is scheduled to expire after September 30, 1991.

(b) Medicare as Secondary Payer for the Disabled—Medicare is secondary payer for disability beneficiaries who are covered by a "large group health plan". A large group health plan may not take into account that an active, disabled individual is entitled to this provision.

This provision is scheduled to expire before January 1, 1992.

Explanation of Provision

(a) Identification of Medicare Secondary Payer Situations—The provision, scheduled to expire after September 30, 1991, would be extended through September 30, 1995.

(b) Medicare as Secondary Payer for the Disabled—This provision, scheduled to expire before January 1, 1992, would be extended through September 30, 1995.

Effective Date

Effective upon the date of enactment.

Subtitle D—Provisions Pertaining to Medicare Part B Premium and Deductible

Sec. 12301—Part B Premium

Present Law

Part B is a voluntary program financed by premiums paid by aged, disabled and chronic renal disease enrollees and by general revenues of the Federal government. The premium rate is derived annually based partly upon the projected costs of the program for the coming year. Under prior law, the premium rate was changed on July 1 of each year. The Social Security Amendments of 1983 moved the premium increase to January 1 of each year to coincide with the changed date for the annual Social Security cash benefit cost-of-living adjustment (COLA).

Ordinarily, the premium rate is the lower of (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the COLA provisions of the Social Security program.

Low-income beneficiaries are protected from the full effect of premium increases by two provisions. First, premium increases are constrained to prevent social security benefits, from which the premiums are deducted, from declining in absolute amount. Second, the Medicare Catastrophic Coverage Act provided for Medicaid payment of premiums for individuals below the poverty line.

From 1984 through 1990, the premium was set at 25 percent of program costs for aged beneficiaries. The remaining 75 percent was covered by general revenues. In CY 1990, the basic Part B premium is \$28.60.

Proposed Amendment to Summit Agreement

The Part B premium would be set as follows: \$32.40 in 1991, \$36.00 in 1992, \$40.50 in 1993, \$44.00 in 1994 and \$46.50 in 1995.

Effective Date

For premiums beginning January 1, 1991.

Sec. 12302—Part B Deductible

Present Law

Part B of Medicare pays 80 percent of the reasonable charges (or of reasonable cost) for covered services in excess of an annual deductible of \$75. The part B deductible has been set at \$75 since 1982.

Explanation of Provision

The Part B deductible would be increased to \$100 in 1991, \$125 in 1992 and in subsequent years.

Effective Date

January 1, 1991.

Subtitle E—User Fees

1. Customs Service

Present Law

Section 13031(a) of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, requires the collection of a user fee to cover the U.S. Customs Service's costs of processing imported merchandise.

Section 111-115 of the Customs and Trade Act of 1990 (Public Law 101-382) reauthorized customs user fees for fiscal year 1991 in order to bring the United States into conformance with the General Agreement on Tariffs and Trade (GATT). The new fee structure for the Merchandise Processing Fee (MPF), subject to certain exemptions, is as follows:

For each formal entry, the revised fee schedule imposes an ad valorem fee of 0.17 percent, subject to a maximum fee of \$400 and a minimum fee of \$21. All entries would be subject to an additional \$3 surcharge if filed manually.

A new flat rate schedule for informal entries (e.g., those under \$1,250) is as follows: (1) \$2 for automated, non-Customs-prepared informal entries; (2) \$5 for manual, non-Customs-prepared informal entries; and (3) \$8 for Customs-prepared informal entries.

In lieu of these informal fees, air courier facilities and other reimbursable facilities are subject to a reimbursement for Customs' processing costs to be collected at a rate of twice the assessment

subsequently filed with the Securities and Exchange Commission by December 31, 1990.

In addition, the provision does not apply to an exchange resulting from a proceeding in a title 11 or similar case that had been filed before October 10, 1990.

6. Employment Tax Provisions

- a. Increase in dollar limitation on amount of wages and self-employment income subject to the Medicare hospital insurance payroll tax (sec. 13341 of the bill and sec. 3121 of the Code)**

Present Law

As part of the Federal Insurance Contributions Act (FICA), a tax is imposed on employees and employers up to a maximum amount of employee wages. The tax is comprised of two parts: old-age, survivor, and disability insurance (OASDI) and Medicare hospital insurance (HI). For wages paid in 1990 to covered employees, the HI tax rate is 1.45 percent on both the employer and the employee on the first \$51,300 of wages and the OASDI tax rate is 6.2 percent on both the employer and the employee on the first \$51,300 of wages.

Under the Self-Employment Contributions Act of 1954 (SECA), a tax is imposed on an individual's self-employment income. The self-employment tax rate is the same as the total rate for employers and employees (i.e., 2.9 percent for HI and 12.40 percent for OASDI). For 1990, the tax is applied to the first \$51,300 of self-employment income and, in general, the tax is reduced by any wages for which employment taxes were withheld during the year.

The cap on wages and self-employment income subject to FICA and SECA taxes is indexed to changes in the average wages in the economy. In 1991, the amount of wages or self-employment income subject to the tax is projected to be \$54,300.

Reasons for Change

The committee believes that increasing the cap on wages and self-employment income subject to tax with respect to the HI tax will improve the progressivity of the tax system. In addition, increased revenues under the bill will provide necessary funding for the Hospital Insurance Trust Fund and will enhance its long-term solvency.

Explanation of Provision

The bill increases the cap on wages and self-employment income considered in calculating HI tax liability to \$73,000. As under present law, for years beginning after 1991, this cap is indexed to changes in the average wages in the economy. The OASDI wage cap remains at the level provided under present law.

Effective Date

The provision is effective on January 1, 1991.

b. Extending Medicare coverage of, and application of hospital insurance tax to, all State and local government employees (sec. 13342 of the bill and sec. 3121 of the Code)

Present law

Before enactment of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), State and local workers were covered under Medicare only if the State and the Secretary of Health and Human Services entered into a voluntary agreement providing for such coverage. In COBRA, the Congress extending Medicare coverage (and the corresponding hospital insurance (HI) payroll tax) on a mandatory basis to State and local government employees (other than students) hired after March 31, 1986.

For wages paid in 1990 to Medicare-covered employees, the total HI tax rate is 2.9 percent of the first \$51,300 of wages. The tax is divided equally between the employer and the employee.

Reasons for Change

The committee believes Medicare coverage should be extended to all employees of State and local governments. In addition, evidence suggests that a substantial number of former employees of State and local governments are entitled to receive Medicare coverage due to other employment or spousal Medicare eligibility. These employees contribute less to the financing of the Medicare system than employees who are entitled to the same benefits, but who spend their entire working career in Medicare-covered employment. Therefore, the committee believes that State and local employees hired before April 1, 1986, (and their employers) should be liable for the HI tax in the same manner as is required of Federal Government employees, State and local government employees hired after March 31, 1986, and private sector employees.

Explanation of Provision

The bill requires coverage of all employees of State and local governments under Medicare without regard to the employee's date of hire. The 2.9 percent HI payroll tax rate is imposed on employers and employees and is phased in with respect to newly covered State and local government employees so that the tax rate is 1.6 percent in 1992; 2.7 percent in 1993; and 2.9 percent in 1994 and thereafter. The present-law student exception is retained with respect to students employed in public schools, colleges, and universities. Coverage may, as under present law, continue to be provided to such individuals at the option of the State government.

In the case of employees who are required to pay the HI tax as a result of this provision and who meet certain other requirements, certain services performed for a State and local government prior to the effective date are deemed to have been covered by the HI tax for purposes of determining Medicare eligibility. Prior State and local service is counted regardless of whether such service was continuous.

The provision authorizes the appropriation of funds to the HI trust fund for any additional cost arising by reason of this provision.

The Secretary of Health and Human Services is required to provide a process by which employees may provide evidence of prior State and local governmental service if such service is necessary to qualify for coverage under the program.

Effective Date

The provision is effective with respect to services performed after December 31, 1991.

- c. Extend social security retirement coverage (OASDI) to State and local government employees not covered by a public employee retirement program (sec. 13343 of the bill and sec. 3121 of the Code)**

Present Law

Employees of State and local governments are covered under social security by voluntary agreements entered into by the States with the Secretary of Health and Human Services (HHS). After a State has entered into such an agreement, it may decide, or permit its political subdivisions to decide, whether to include particular groups of employees under the agreement. All States have entered into such agreements. The extent of coverage is high in some States and limited in others. Nationally, about 72 percent of State and local workers are covered by social security.

With certain exceptions, a State has broad latitude to decide which groups of State and local employees are covered under its agreement. In some cases in which States have elected not to provide coverage, a part of the workforce does not participate in any public retirement plan.

For 1990, the social security (Old Age, Survivors, and Disability Insurance) tax rate is 6.2 percent of covered wages up to \$51,300 and is imposed on both the employer and employee (for a total of 12.40 percent).

Reasons for Change

Certain employees of State and local governments have no retirement protection either from social security or a public retirement system. Many of these individuals are low-paid individuals with limited or intermittent work experience and, therefore, social security coverage will provide important disability and retirement protection.

Explanation of Provision

Under the bill, State and local workers who are not covered by a retirement system in conjunction with their employment for the State or local government are required to be covered by social security (Old Age, Survivors, and Disability Insurance (OASDI)) and such workers' wages are subject to the OASDI taxes under the Federal Insurance Contributions Act (FICA).

A retirement system is defined as under the definition of retirement system contained in the Social Security Act (42 U.S.C. sec. 418(b)(4)). Thus, a retirement system is defined as a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof.

Whether an employee is a member (i.e., is a participant) of a retirement system is based upon whether that individual actually participates in the program. Thus, whether an employee participates is not determined by whether that individual holds a position that is included in a retirement system. Instead, that individual must actually be a member of the system. For example, an employee whose job classification is of a type that ordinarily is entitled to coverage is not a member of a retirement system if he or she is ineligible because of age or service conditions contained in the plan and, therefore, is required to be covered under social security. Similarly, if participation in the system is elective, and the employee elects not to participate, that employee does not participate in a system for purposes of this rule, and is to be covered under the social security system.

The Secretary of the Treasury, in conjunction with the Social Security Administration, is required to issue guidance in order to implement the purposes of this provision.

Effective Date

The provision is effective with respect to services performed after September 30, 1990.

d. Increase in Railroad Retirement tier 2 payroll taxes (sec. 13344 of the bill and secs. 3201, 3211, and 3221 of the Code)

Present Law

Railroad employers, employees, and employee representatives are subject to a payroll tax to fund tier 2 railroad retirement benefits. The tax rate is 4.90 percent for employees, 16.10 percent for employers, and 14.75 percent for employee representatives. In 1990, the tax is imposed on wages up to a maximum of \$38,100. In 1991, this wage base is projected to increase to \$40,500.

Reasons for Change

The committee believes that an increase in the tier 2 payroll tax will improve the long-term solvency of the Railroad Retirement Account.

Explanation of Provision

The provision increases the tier 2 tax rate by 0.10 percent for employees (for a total rate of 5.00 percent), 0.30 percent for employers (for a total rate of 16.40 percent), and 0.30 percent for employee representatives (for a total rate of 15.05 percent).

D. INFLATIONARY IMPACT

In compliance with clause 2(l)(4) of Rule XI of the Rules of the House of Representatives, the Committee states that the enactment of Titles XII and XIII is expected to significantly reduce inflationary pressures in the operation of the national economy.

E. BUDGET EFFECTS OF THE BILL

1. COMMITTEE ESTIMATES

In compliance with clause 7(a) of Rule XIII of the House of Representatives, the following statement is made:

The Committee agrees with the estimates prepared by the Congressional Budget Office (CBO) which is included below.

Table 1 below summarizes the budget effect (both outlays and revenues) by major program. These estimates are identical to those made by CBO and the Joint Committee on Taxation. Only provisions which have a direct impact upon budget outlays or revenues are shown in these tables.

The reconciliation target (both outlays and revenues) was \$18.5 billion in fiscal year 1991 and \$194.4 billion over the 5-year period. The bill as reported by the Committee has achieved total deficit reduction of \$23.9 billion in fiscal year 1991 and \$198.2 billion over the 5-year period. Thus, the Committee has more than met its obligation under the budget resolution.

Table 2 presents the outlay impact for each Medicare provision in Title XII, and Table 3 presents the revenue impact for each revenue provision in Title XIII.

TABLE 1.—COMMITTEE ON WAYS AND MEANS RECONCILIATION INSTRUCTION AND RECONCILIATION LEGISLATION AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS

[By fiscal year, in billions of dollars]

	1991	1992	1993	1994	1995	5-year
Reconciliation Instruction						
Revenues.....	-13.225	-24.135	-24.040	-28.950	-28.450	-118.800
Outlays.....	-3.320	-9.245	-11.870	-14.148	-17.020	-55.603
Unspecified Deficit Reduction.....	-2.000	-3.000	-4.000	-5.000	-6.000	-20.000
Committee Total.....	-18.545	-36.380	-39.910	-48.098	-51.470	-194.403
Budget Effects of the Reconciliation Legislation As Reported by the Committee on Ways and Means						
Medicare						
Medicare Program.....	-3.268	-5.712	-7.242	-8.042	-8.823	-33.087
Medicare Beneficiaries.....	-1.040	-2.450	-3.750	-4.695	-5.285	-17.220
Total Medicare.....	-4.308	-8.162	-10.992	-12.737	-14.108	-50.307
Social Security (Overpayments).....	0.000	-0.043	-0.028	0.000	0.000	-0.071
Customs Service User Fees.....	0.000	-0.572	-0.562	-0.568	-0.590	-2.292
IRS User Fees.....	-0.045	-0.045	-0.045	-0.045	-0.045	-0.225
PBGC.....	-0.120	-0.130	-0.130	-0.130	-0.130	-0.640
Revenues.....	-19.400	-31.600	-27.900	-32.200	-33.600	-144.700
Committee Total.....	-23.873	-40.552	-39.657	-45.680	-48.473	-198.235

Note: Minus sign denotes a reduction in the deficit—outlay reduction or revenue increase.

TABLE 2. MEDICARE PROVISIONS

[By fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	5-year
Part A						
1. Hospital Capital —15%, PPS FY91 (10/90).....	-810	-120	0	0	0	-930
2. Hospital Update—wage/regional adj.	-495	-2105	-2710	-2820	-3045	-11,175
—2.0% for FY91 (1/91)						
—1.5% net FY92; capital 100%,						
—3.55% update						
—1.0% in FY93						
3. DRG Payment Window of 72 hours (1/91).....	-75	-135	-150	-165	-185	-710
4. Graduate Medical Education (7/91).....	-35	-70	-95	-150	-165	-515
5. PPS-Exempt Hospitals	-60	-75	-10	0	0	-145
6. Cont. FY90 payment policies 11/1-12/31/90.....	-425	0	0	0	0	-425
Total—Part A	-1900	-2505	-2965	-3135	-3395	-13,900
Part B						
7. Overpriced Physician Procedures						
50% in FY91	-250	-410	-450	-500	-555	-2165
RAPs —6% in FY91	-160	-265	-295	-350	-385	-1455
Subtotal—Overpriced Proce-	-410	-675	-745	-850	-940	-3620
dures.....						
8. Physician Update.....	-235	-500	-610	-675	-755	-2775
0% in 91; primary care/floor						
2% in 92						
9. Other Physician Provisions						
New physicians	-50	-95	-110	-125	-135	-515
Assistants at Surgery	-30	-50	-55	-60	-65	-260
Interpretation of EKGs 1/92)	0	-135	-225	-250	-275	-885
Subtotal—Other Physicians	-80	-280	-390	-435	-475	-1660
10. Hospital Outpatient Services.....	-278	-436	-521	-415	-360	-2010
Capital at —15% thru 12/93 (10/90)						
Services at —2% thru 12/93 (10/90)						
Surg./Rad. limits to 33/67% (1/91)						
11. Durable Medical Equipment	-185	-351	-431	-502	-548	-2017
12. Clinical Laboratory Services	-85	-175	-250	-300	-340	-1150
13. Cont. FY90 —1/4% policy 11/1-12/31/90.....	-70	0	0	0	0	-70
Total—Part B	-1343	-2417	-2947	-3177	-3418	-13,302
Part A and B						
14. ESRD	-25	-40	-40	-40	-40	-185
15. Secondary Payer Extensions	0	-750	-1290	-1690	-1970	-5700
Total—Part A and B	-25	-790	-1330	-1730	-2010	-5885
Total—Medicare Program	-3268	-5712	-7242	-8042	-8823	-33,087
Medicare Beneficiary Provisions						
16. Part B Premium Increases Set—ad hoc increase.....	-690	-1560	-2650	-3565	-4125	-12,590
17. Part B Deductible \$100 in CY91, \$100 in 92-95.....	-350	-890	-1100	-1130	-1160	-4630
Total—Medicare Beneficiaries.....	-1040	-2450	-3750	-4695	-5285	-17,220

Note: {date} denotes effective date of the provision.

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURE

In compliance with clause 2(1)(3)(B) of Rule XI of the House of Representatives, the Committee states that the letter from the Congressional Budget Office indicates that there are changes in budget authority, new spending authority as described in Section 401(c)(2) of the Congressional Budget Act of 1974, and on tax expenditures as a result of the reconciliation provisions of Titles XII and XIII. These are identified in the CBO letter below.

3. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with Clause 2(1)(3)(C) of Rule XI of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by the CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 15, 1990.

Hon. DAN ROSTENKOWSKI,
*Chairman, Committee on Ways and Means,
United States House of Representatives,
Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for the Reconciliation provisions of the Committee on Ways and Means, as ordered transmitted to the House Committee on the Budget, October 15, 1990.

The estimates included in the attached table represent the 1991-1995 effects on the federal budget and on the budget resolution baseline of the Committee's legislative proposals affecting spending. CBO understands that the Committee on the Budget will be responsible for interpreting how savings contained in these legislative proposals measure against the budget resolution reconciliation instructions.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER,
Director.

TITLE XII—COMMITTEE ON WAYS AND MEANS: SPENDING PROVISIONS-SUBTITLES A THROUGH E AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS

[By fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	Total 1991- 95
DIRECT SPENDING						
SUBTITLE A—PROVISIONS RELATING TO MEDICARE PART A						
Sec. 12001. Reductions in payments for capital-related costs of inpatient PPS hospital services for fiscal year 1991....	—810	—120	0	0	0	—930
Sec. 12002. Prospective payment hospi- tals.....	—495	—2,105	—2,710	—2,820	—3,045	—11,175

**TITLE XII—COMMITTEE ON WAYS AND MEANS: SPENDING PROVISIONS—SUBTITLES A THROUGH E AS
REPORTED BY THE COMMITTEE ON WAYS AND MEANS—Continued**

[By fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	Total 1991- 95
Sec. 12003. Expansion of DRG payment window.....	-75	-135	-150	-165	-185	-710
Sec. 12004. Payments for direct graduate medical education costs.....	-35	-70	-95	-150	-165	-515
Sec. 12005. PPS-Exempt hospitals.....	-60	-75	-10	0	0	-145
Sec. 12006. Freeze in payments under part A through December 31.....	-425	0	0	0	0	-425
Subtotal-Subtitle A.....	-1,900	-2,505	-2,965	-3,135	-3,395	-13,900
SUBTITLE B—PROVISIONS RELATING TO MEDICARE PART B						
Sec. 12101. Reduction in payments for overvalued procedures.....	-250	-410	-450	-500	-555	-2,165
Sec. 12102. Payment for radiology services.....	-120	-205	-230	-265	-295	-1,115
Sec. 12103. Anesthesia services.....	-35	-50	-55	-70	-75	-285
Sec. 12104. Pathology services.....	-5	-10	-10	-15	-15	-55
Sec. 12105. Payments for physicians' services.....	-235	-500	-610	-675	-755	-2,775
Sec. 12106. Treatment of new physicians.....	-50	-95	-110	-125	-135	-515
Sec. 12107. Payments for assistants at surgery.....	-30	-50	-55	-60	-65	-260
Sec. 12108. Interpretation of electrocardiograms.....	0	-135	-225	-250	-275	-885
Sec. 12111. Payments for hospital outpatient services.....	-278	-436	-521	-415	-360	-2,010
Sec. 12112. Durable medical equipment.....	-185	-351	-431	-502	-548	-2,017
Sec. 12113. Payments for clinical diagnostic laboratory tests.....	-85	-175	-250	-300	-340	-1,150
Sec. 12114. Reduction in payments under part B during final 2 months of 1990.....	-70	0	0	0	0	-70
Subtotal—Subtitle B.....	-1,343	-2,417	-2,947	-3,177	-3,418	-13,302
SUBTITLE C—PROVISIONS RELATING TO MEDICARE PART A AND B						
Sec. 12201. End state renal disease services.....	-25	-40	-40	-40	-40	-185
Sec. 12202. Extension of secondary payor provisions.....	0	-750	-1,290	-1,690	-1,970	-5,700
Subtotal—Subtitle C.....	-25	-790	-1,330	-1,730	-2,010	-5,885
SUBTITLE D—PROVISIONS RELATING TO MEDICARE PART B PREMIUM AND DEDUCTIBLE						
Sec. 12301. Part B premium.....	-690	-1,560	-2,650	-3,565	-4,125	-12,590
Sec. 12302. Part B deductible.....	-350	-890	-1,100	-1,130	-1,160	-4,630
Subtotal—Subtitle D.....	-1,040	-2,450	-3,750	-4,695	-5,285	-17,220
SUBTITLE E—USER FEES						
Sec. 12401. 4-year extension of customs user fees.....	0	-572	-562	-568	-590	-2,292
Sec. 12402. 5-year extension of internal revenue user fees *.....	-45	-45	-45	-45	-45	-225
Sec. 12403. Increase in PBGC premium rates.....	-120	-130	-130	-130	-130	-640

TITLE XII—COMMITTEE ON WAYS AND MEANS: SPENDING PROVISIONS—SUBTITLES A THROUGH E AS
REPORTED BY THE COMMITTEE ON WAYS AND MEANS—Continued

[By fiscal year, in millions of dollars]

	1991	1992	1993	1994	1995	Total 1991- 95
Sec. 12404. Recovery of OASDI overpay- ments by means of reduction in tax refunds	0	-43	-28	0	0	-71
Subtotal—Subtitle E	165	-790	-765	-743	-765	-3,228
Total—Title XII	-4,473	-8,952	-11,757	-13,480	-14,873	-53,535
State and local effects	-25	-45	-120	-200	-290	-680

* Revenue increase. Negative sign represents the deficit effect.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 15, 1990.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means,
United States House of Representatives,
Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office concurs with the Joint Committee on Taxation estimates of the revenue effects of the tax provisions included among the Reconciliation provisions of the Committee on Ways and Means.

Sincerely,

ROBERT D. REISCHAUER

EDUCATION AND TRAINING (500)

Increases over current services provided for under this function should reach, at least, \$2.4 billion in Budget Authority and \$2.0 billion in Outlays by FY 1993 and, to the degree possible, be targeted to fund the Carl D. Perkins Vocational Education Act, the School Lunch and Child Nutrition Act, Head Start and Handicapped Education, to create Educational R&D Districts for educational research and development, Youth Incentive, Employment, Drop-Out Prevention and Anti-Gang Violence programs, and to create a new government guaranteed bond program to raise capital improvement funds for private Historically Black Colleges and Universities

INCOME SECURITY (600)

Increases over current services provided for under this function should reach, at least, \$1.5 billion in Budget Authority and \$1.5 billion in Outlays by FY 1993 and, to the degree possible, be targeted to fund WIC, School Breakfast and Child Care Food programs, AFDC Assistance and Community Food Nutrition, AFDC Work Activities, Job Opportunities and Basic Skills (JOBS) Training and Snack to Child Care and Temporary Emergency Food Assistance programs

VETERANS BENEFITS AND SERVICES (700)

Increases over current services provided for under this function should reach, at least, \$500 million in Budget Authority and \$500 million in Outlays by FY 1993 and, to the degree possible, be targeted for expanding Education, Training and Rehabilitation and for increases in Veterans Housing, Hospital and Medical benefits

We look forward to working with the Congressional Black Caucus on this important matter.



OMNIBUS BUDGET RECONCILIATION ACT
OF 1990

CONFERENCE REPORT

TO ACCOMPANY

H.R. 5835



OCTOBER 27 (legislative day, OCTOBER 26), 1990.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1990

OMNIBUS BUDGET RECONCILIATION ACT OF 1990

OCTOBER 27 (legislative day, OCTOBER 26), 1990.—Ordered to be printed

Mr. PANETTA, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 5835]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 5835) to provide for reconciliation pursuant to section 4 of the concurrent resolution on the budget for fiscal year 1991, have met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Omnibus Budget Reconciliation Act of 1990".

SEC. 2. TABLE OF TITLES.

- Title I. Agriculture and related programs.*
- Title II. Banking, housing, and related programs.*
- Title III. Student loans and labor provisions.*
- Title IV. Medicare, medicaid, and other health-related programs.*
- Title V. Income security, human resources, and related programs.*
- Title VI. Energy and environmental programs.*
- Title VII. Civil service and postal service programs.*
- Title VIII. Veterans' programs.*
- Title IX. Transportation.*
- Title X. Miscellaneous user fees and other provisions.*
- Title XI. Revenue provisions.*
- Title XII. Pensions.*
- Title XIII. Budget enforcement.*

TITLE I—AGRICULTURE AND RELATED PROGRAMS

SEC. 1001. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This title may be cited as the “Agricultural Reconciliation Act of 1990”.

(b) **TABLE OF CONTENTS.**—The table of contents of this title is as follows:

Sec. 1001. Short title; table of contents.

Subtitle A—Commodity Programs

Sec. 1101. Triple base for deficiency payments.

Sec. 1102. Calculation of deficiency payments based on 12-month average.

Sec. 1103. Acreage reduction program for 1991 crop.

Sec. 1104. Acreage reduction programs for 1992 through 1995 crops.

Sec. 1105. Loan origination fees and other savings.

Subtitle B—Other Agricultural Programs

Sec. 1201. Authorization levels for rural electric and telephone loans.

Sec. 1202. Authorization levels for FmHA loans.

Sec. 1203. APHIS inspection user fee on international passengers.

Sec. 1204. Additional savings and other provisions.

Subtitle C—Effective Date

Sec. 1301. Effective date.

Sec. 1302. Readjustment of support levels.

Subtitle A—Commodity Programs

SEC. 1101. TRIPLE BASE FOR DEFICIENCY PAYMENTS.

(a) **WHEAT.**—Section 107B(c)(1)(C)(ii) of the Agricultural Act of 1949 (as added by section 301 of the Food, Agriculture, Conservation, and Trade Act of 1990) is amended by striking “100 percent” and inserting “85 percent”.

(b) **FEED GRAINS.**—Section 105B(c)(1)(C)(ii) of the Agricultural Act of 1949 (as added by section 401 of the Food, Agriculture, Conservation, and Trade Act of 1990) is amended by striking “100 percent” and inserting “85 percent”.

(c) **UPLAND COTTON.**—Section 103B(c)(1)(C)(ii) of the Agricultural Act of 1949 (as added by section 501 of the Food, Agriculture, Conservation, and Trade Act of 1990) is amended by striking “100 percent” and inserting “85 percent”.

(d) **RICE.**—Section 101B(c)(1)(C)(ii) of the Agricultural Act of 1949 (as added by section 601 of the Food, Agriculture, Conservation, and Trade Act of 1990) is amended by striking “100 percent” and inserting “85 percent”.

SEC. 1102. CALCULATION OF DEFICIENCY PAYMENTS BASED ON 12-MONTH AVERAGE.

(a) **WHEAT.**—Clause (ii) of section 107B(c)(1)(B) of the Agricultural Act of 1949 (as added by section 301 of the Food, Agriculture, Conservation, and Trade Act of 1990) is amended to read as follows:

“(ii) **PAYMENT RATE OF 1994 AND 1995 CROPS.**—The payment rate for each of the 1994 and 1995 crops of

Subtitle B—Labor Related Penalties

SEC. 3101. OCCUPATIONAL SAFETY AND HEALTH.

Section 17 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 666) is amended—

(1) in subsection (a), by striking “\$10,000 for each violation” and inserting “\$70,000 for each violation, but not less than \$5,000 for each willful violation; and

(2) in subsections (b), (c), (d), and (i), by striking “\$1,000” and inserting “\$7,000”.

SEC. 3102. MINE SAFETY AND HEALTH.

Section 110 of the Federal Mine Safety and Health Act of 1977 (30 U.S.C. 820) is amended—

(1) in subsection (a), by striking “\$10,000” and inserting “\$50,000”; and

(2) in subsection (b), by striking “1,000” and inserting “\$5,000”, and

SEC. 3103. FAIR LABOR STANDARDS.

Section 16(e) of the Fair Labor Standards Act of 1938 (29 U.S.C. 216(e)) is amended—

(1) in the first sentence—

(A) by striking “or any person who repeatedly or willfully violates section 6 or 7”; and

(B) by striking “not to exceed \$1,000 for each such violation” and inserting “not to exceed \$10,000 for each employee who was the subject of such a violation”;

(2) by inserting after the first sentence the following: “Any person who repeatedly or willfully violates section 6 or 7 shall be subject to a civil penalty of not to exceed \$1,000 for each such violation.”;

(3) by striking “such penalty” each place the term appears except after “appropriateness of” and inserting “any penalty under this subsection”; and

(4) in the last sentence, by striking “Sums” and inserting “Except for civil penalties collected for violations of section 12, sums”; and

(5) by inserting at the end the following new sentence: “Civil penalties collected for violations of section 12 shall be deposited in the general fund of the Treasury.”.

TITLE IV—MEDICARE, MEDICAID, AND OTHER HEALTH-RELATED PROGRAMS

Subtitle A—Medicare

SEC. 4000. REFERENCES IN SUBTITLE; TABLE OF CONTENTS.

(a) **AMENDMENTS TO THE SOCIAL SECURITY ACT.**—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) *TABLE OF CONTENTS.*—The table of contents of this subtitle is as follows:

Sec. 4000. References in subtitle; table of contents.

PART 1—PROVISIONS RELATING TO PART A

- Sec. 4001. Payments for capital-related costs of inpatient hospital services.*
- Sec. 4002. Prospective payment hospitals.*
- Sec. 4003. Expansion of DRG payment window.*
- Sec. 4004. Payments for medical education costs.*
- Sec. 4005. PPS-exempt hospitals.*
- Sec. 4006. Hospice benefit extension.*
- Sec. 4007. Freeze in payments under part A through December 31.*
- Sec. 4008. Miscellaneous and technical provisions relating to part A.*

PART 2—PROVISIONS RELATING TO PART B

SUBPART A—PAYMENT FOR PHYSICIANS' SERVICES

- Sec. 4101. Certain overvalued procedures.*
- Sec. 4102. Radiology services.*
- Sec. 4103. Anesthesia services.*
- Sec. 4104. Physician pathology services.*
- Sec. 4105. Update for physicians' services.*
- Sec. 4106. New physicians and other new health care practitioners.*
- Sec. 4107. Assistants at surgery.*
- Sec. 4108. Technical components of certain diagnostic tests.*
- Sec. 4109. Interpretation of electrocardiograms.*
- Sec. 4110. Reciprocal billing arrangements.*
- Sec. 4111. Study of prepayment medical review screens.*
- Sec. 4112. Practicing physicians advisory council.*
- Sec. 4113. Study of aggregation rule for claims for similar physicians' services.*
- Sec. 4114. Utilization screens for physician visits in rehabilitation hospitals.*
- Sec. 4115. Study of regional variations in impact of medicare physician payment reform.*
- Sec. 4116. Limitation on beneficiary liability.*
- Sec. 4117. Statewide fee schedule areas for physicians' services.*
- Sec. 4118. Technical corrections.*

SUBPART B—OTHER ITEMS AND SERVICES

- Sec. 4151. Payments for hospital outpatient services.*
- Sec. 4152. Durable medical equipment.*
- Sec. 4153. Provisions relating to orthotics and prosthetics.*
- Sec. 4154. Clinical diagnostic laboratory tests.*
- Sec. 4155. Coverage of nurse practitioners in rural areas.*
- Sec. 4156. Coverage of injectable drugs for treatment of osteoporosis.*
- Sec. 4157. Separate payment under part B for services of certain health practitioners.*
- Sec. 4158. Reduction in payments under part B during final 2 months of 1990.*
- Sec. 4159. Payments for medical education costs.*
- Sec. 4160. Certified registered nurse anesthetists.*
- Sec. 4161. Community health centers and rural health clinics.*
- Sec. 4162. Partial hospitalization in community mental health centers.*
- Sec. 4163. Coverage of screening mammography.*
- Sec. 4164. Miscellaneous and technical provisions relating to part B.*

PART 3—PROVISIONS RELATING TO PARTS A AND B

- Sec. 4201. Provisions relating to end stage renal disease.*
- Sec. 4202. Staff-assisted home dialysis demonstration project.*
- Sec. 4203. Extension of secondary payor provisions.*
- Sec. 4204. Health maintenance organizations.*
- Sec. 4205. Peer review organizations.*
- Sec. 4206. Medicare provider agreements assuring the implementation of a patient's right to participate in and direct health care decisions affecting the patient.*
- Sec. 4207. Miscellaneous and technical provisions relating to parts A and B.*

PART 4—PROVISIONS RELATING TO PART B PREMIUM AND DEDUCTIBLE

- Sec. 4301. Part B premium.
 Sec. 4302. Part B deductible.

PART 5—MEDICARE SUPPLEMENTAL INSURANCE POLICIES

- Sec. 4351. Simplification of medicare supplemental policies.
 Sec. 4352. Guaranteed renewability.
 Sec. 4353. Enforcement of standards.
 Sec. 4354. Preventing duplication.
 Sec. 4355. Loss ratios and refund of premiums.
 Sec. 4356. Clarification of treatment of plans offered by health maintenance organizations.
 Sec. 4357. Pre-existing condition limitations and limitation on medical underwriting.
 Sec. 4358. Medicare select policies.
 Sec. 4359. Health insurance advisory services for medicare beneficiaries.
 Sec. 4360. Health insurance information, counseling, and assistance grants.
 Sec. 4361. Medicare and medigap information by telephone.

PART 1—PROVISIONS RELATING TO PART A

SEC. 4001. PAYMENTS FOR CAPITAL-RELATED COSTS OF INPATIENT HOSPITAL SERVICES.

(a) **REDUCTION IN PAYMENTS FOR FISCAL YEAR 1991.**—Section 1886(g)(3)(A)(v) (42 U.S.C. 1395ww(g)(3)(A)(v)) is amended by striking “September 30, 1990” and inserting “September 30, 1991”.

(b) **IMPLEMENTATION OF PROSPECTIVE PAYMENT FOR CAPITAL-RELATED COSTS.**—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)) is amended by adding at the end the following: “Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1861(v)).”

(c) **EXEMPTION FOR RURAL PRIMARY CARE HOSPITALS.**—Section 1886(g)(3)(B) is amended by striking “subsection (d)(5)(D)(iii).” and inserting “subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).”

SEC. 4002. PROSPECTIVE PAYMENT HOSPITALS.

(a) **CHANGES IN UPDATE FACTORS.**—

(1) **IN GENERAL.**—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(A) by striking “and” at the end of subclause (V);

(B) in subclause (VI)—

(i) by striking “1991” and inserting “1994”, and

(ii) by redesignating such subclause as subclause (IX); and

(C) by inserting after subclause (V) the following new subclauses:

“(VI) for fiscal year 1991, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

“(VII) for fiscal year 1992, the market basket percentage increase minus 1.6 percentage points for hospitals in all areas,

"(VIII) for fiscal year 1993, the market basket percentage increase minus 1.55 percentage point for hospitals in all areas, and".

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to payments for discharges occurring on or after January 1, 1991.

(b) **CHANGES IN DISPROPORTIONATE SHARE PAYMENTS.**—

(1) **INCREASE FOR URBAN HOSPITALS WITH MORE THAN 100 BEDS.**—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended—

(A) in subclause (I), by striking "greater than 20.2," and all that follows and inserting the following: "greater than 20.2—

"(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P-20.2)(.65) + 5.62,

"(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P-20.2)(.7) + 5.62,

"(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, (P-20.2)(.8) + 5.88, and

"(d) for discharges occurring on or after October 1, 1994, (P-20.2)(.825) + 5.88; or"; and

(B) in subclause (II), by striking "hospital, (P-15)(.6) + 2.5," and inserting the following: "hospital—

"(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P-15)(.6) + 2.5,

"(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P-15)(.6) + 2.5,

"(c) for discharges occurring on or after October 1, 1993, (P-15)(.65) + 2.5."

(2) **INCREASE FOR HOSPITALS WITH DISPROPORTIONATE INDIGENT CARE REVENUES.**—Section 1886(d)(5)(F)(iii) (42 U.S.C. 1395ww(d)(5)(F)(iii)) is amended by striking "30 percent" and inserting "35 percent".

(3) **REPEAL OF SUNSET.**—

(A) **IN GENERAL.**—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by striking "and before October 1, 1995," each place it appears in paragraph (2)(C)(iv) and paragraph (5)(F)(i).

(B) **CONFORMING AMENDMENTS.**—(A) Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)) is amended to read as follows:

"(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring on or after May 1, 1986, is equal to $1.89 \times (((1 + r) \text{ to the } n\text{th power}) - 1)$, where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405."

(B) Section 1886(d)(3)(C)(ii) (42 U.S.C. 1395ww(d)(3)(C)(ii)) is amended by striking "occurring—" and all that follows and inserting the following: "occurring on or after October 1, 1986, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Rec-

conciliation Amendments of 1985 and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987 if the factor described in clause (ii)(II) of paragraph (5)(B) (determined without regard to amendments made by the Omnibus Budget Reconciliation Act of 1990) were applied for discharges occurring on or after such date instead of the factor described in clause (ii) of that paragraph.”.

(4) **NO RESTANDARDIZING FOR RECENT ADJUSTMENTS.**—

(A) **ADJUSTMENTS UNDER OBRA 1989.**—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended by striking the period at the end and inserting the following: “, except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989.”.

(B) **ADJUSTMENTS UNDER OBRA 1990.**—Section 1886(d)(2)(C)(iv), as amended by subparagraph (A), is further amended by striking “1989.” and inserting “1989 or the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990.”.

(5) **EFFECTIVE DATE.**—The amendments made by paragraphs (1), (3), and (4)(B) shall apply to discharges occurring on or after January 1, 1991, the amendment made by paragraph (2) shall apply to discharges occurring on or after October 1, 1991, and the amendment made by paragraph (4)(A) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

(c) **PAYMENTS TO RURAL HOSPITALS.**—

(1) **PHASE-OUT OF SEPARATE AVERAGE STANDARDIZED AMOUNTS.**—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)), as amended by subsection (a)(1), is further amended—

(A) in subclause (VI), by striking “in all areas,” and inserting “in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,”;

(B) in subclause (VII), by striking “in all areas,” and inserting “in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,”;

(C) in subclause (VIII), by striking “in all areas, and” and inserting “in a large urban or other urban area, and the market basket percentage increase minus 0.55 for hospitals located in a rural area,”;

(D) in subclause (IX)—

(i) by striking “1994” and inserting “1996”, and

(ii) by redesignating such subclause as subclause (XI); and

(E) by inserting after subclause (VIII) the following new subclauses:

“(IX) for fiscal year 1994, the market basket percentage increase for hospitals located in a large urban or other urban area, and the market basket percentage increase plus 1.5 percentage points for hospitals located in a rural area,

"(X) for fiscal year 1995, the market basket percentage increase for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area), and".

(2) CONFORMING AMENDMENTS.—(A) Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)) is amended—

(i) in clause (ii), by striking "(A) and (E)," and inserting "(A), (C), (D), and (E).";

(ii) in subparagraphs (C)(ii) and (D)(ii), by striking "(B)(i)" each place it appears and inserting "(B)(ii)".

(B) Section 1886(d) (42 U.S.C. 1395ww(d)) is amended—

(i) in paragraph (1)(A)(iii), by striking "rural, large urban, or other urban area" and inserting "large urban or other area";

(ii) in paragraph (3)(A)—

(I) in clause (ii), by striking "the Secretary" and inserting "and ending on or before September 30, 1994, the Secretary";

(II) by redesignating clause (iii) as clause (v), and

(III) by inserting after clause (ii) the following new clauses:

"(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an other urban area.

"(iv) For discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.";

(iii) in paragraph (3)(B), by striking "for hospitals located in an urban area" and all that follows and inserting the following: "by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments).";

(iv) in paragraph (3)(D)(i)—

(I) in the matter preceding subclause (I), by striking "an urban area (or," and all that follows through "area)," and inserting "a large urban area"; and

(II) in subclause (I), by striking "an urban area" and inserting "a large urban area";

(v) in paragraph (3)(D)(ii), by striking "a rural area" each place it appears and inserting "other areas"; and

(vi) in paragraph (8)(D)—

(I) in the first sentence, by striking "for hospitals located in an urban area", and

(II) by striking the second sentence.

(3) **EFFECTIVE DATE.**—The amendments made by paragraph (1) and paragraph (2)(A) shall apply to payments for discharges occurring on or after January 1, 1991, and the amendments made by paragraph (2)(B) shall take effect October 1, 1994.

(d) **AREA WAGE INDEX.**—

(1) **DETERMINATION OF AREA WAGE INDEX.**—(A) For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after January 1, 1991, and before October 1, 1993, the Secretary of Health and Human Services shall apply an area wage index determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section.

(B) The Secretary shall apply the wage index described in subparagraph (A) without regard to a previous survey of wages and wage-related costs.

(2) **STUDY OF AREA WAGE INDEX ADJUSTMENTS BASED ON PROFESSIONAL OCCUPATIONAL COMPONENT.**—

(A) **STUDY.**—The Prospective Payment Assessment Commission shall examine available data from States and other sources measuring earnings and paid hours of employment of hospital workers by occupational category, and shall include in such examination an analysis of the impact of variation in occupational mix on the computation of the area wage index determined under section 1886(d)(3)(E) of the Social Security Act.

(B) **REPORT TO CONGRESS.**—In its March 1991 report, the Commission shall include recommendations regarding the feasibility and desirability of modifying such area wage index to take into account occupational mix, including variations in occupational mix resulting from differences in State codes and requirements.

(e) **EXTENSION OF REGIONAL FLOOR ON STANDARDIZED AMOUNTS.**—

(1) **IN GENERAL.**—Section 1886(d)(1)(A)(iii) (42 U.S.C. 1395ww(d)(1)(A)(iii)) is amended by striking "beginning on or after" and all that follows through "1990" and inserting "beginning on or after April 1, 1988, and ending on September 30, 1993,".

(2) **STUDY.**—(A) The Secretary of Health and Human Services shall collect sufficient data on the input prices associated with the non-wage-related portion of the adjusted average standardized amounts established under section 1886(d)(3) of the Social Security Act to identify the extent to which variations in such amounts among hospitals located in different geographic areas are attributable to differences in such prices.

(B) Not later than June 1, 1993, the Secretary shall submit a report to Congress analyzing such data, and shall include in such report recommendations regarding a methodology for adjusting such average standardized amounts to reflect such variations.

(C) The provisions of chapter 35 of title 44, United States Code, shall not apply to data collected by the Secretary under subparagraph (A).

(4) *EFFECTIVE DATE.*—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1990.

(f) *ELIMINATION OF HOSPITAL OFF-SET FOR SERVICES OF PHYSICIAN ASSISTANTS.*—

(1) *IN GENERAL.*—Section 9338 of the Omnibus Budget Reconciliation Act of 1986 is amended by striking subsection (d).

(2) *EFFECTIVE DATE.*—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986.

(g) *RESPONSIBILITIES AND REPORTING REQUIREMENTS OF PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.*—

(1) *EXPANSION OF RESPONSIBILITIES.*—Section 1886(e)(2) (42 U.S.C. 1395ww(e)(2)) is amended—

(A) by striking “(2)” and inserting “(2)(A)”; and

(B) by adding at the end the following new subparagraphs:

“(B) In order to promote the efficient and effective delivery of high-quality health care services, the Commission shall, in addition to carrying out its functions under subparagraph (A), study and make recommendations for each fiscal year regarding changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates and the development of new institutional reimbursement policies under this title, including recommendations relating to payments during such fiscal year under the prospective payment system established under this section for determining payments for the operating costs of inpatient hospital services, including changes in the number of diagnosis-related groups used to classify inpatient hospital discharges under subsection (d), adjustments to such groups to reflect severity of illness, and changes in the methods by which hospitals are reimbursed for capital-related costs, together with general recommendations on the effectiveness and quality of health care delivery systems in the United States and the effects on such systems of institutional reimbursements under this title.

“(C) By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting health care delivery in the United States, including issues relating to—

“(i) trends in health care costs;

“(ii) the financial condition of hospitals and the effect of the level of payments made to hospitals under this title on such condition;

“(iii) trends in the use of health care services; and

“(iv) new methods used by employers, insurers, and others to constrain growth in health care costs.”.

(2) *REPORTING REQUIREMENTS FOR COMMISSION AND SECRETARY; ELIMINATION OF OTA REPORTING REQUIREMENTS.*—Section 1886 (42 U.S.C. 1395ww) is amended—

(A) by striking subparagraph (D) of subsection (d)(4);

(B) in the second sentence of subsection (e)(2)(A), as amended by paragraph (1)(A), by striking “In addition”

and all that follows through "the Commission" and inserting "The Commission";

(C) in subsection (e)(3)(A)—

(i) by striking "the Secretary" and inserting "Congress", and

(ii) by striking the period at the end and inserting the following: "; together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.";

(D) in subsection (e)(4)—

(i) by striking "(4)" and inserting "(4)(A)", and

(ii) by adding at the end the following new subparagraph:

"(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates.";

(E) in subsection (e)(5)—

(i) by striking "recommendation" each place it appears and inserting "recommendations", and

(ii) by adding at the end the following new sentence: "To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations."; and

(F) in subsection (e)(6)(G)—

(i) by striking clause (i), and

(ii) by redesignating clauses (ii) and (iii) as clauses (i) and (ii).

(3) **CONFORMING AMENDMENT.**—Section 1845(c)(1)(D) (42 U.S.C. 1395w-1(c)(1)(D)) is amended by striking "reports and".

(4) **PROPAC STUDY OF MEDICAID PAYMENTS TO HOSPITALS.**—

(A) **STUDY.**—The Prospective Payment Assessment Commission shall conduct a study of hospital payment rates under State plans for medical assistance under title XIX of the Social Security Act, and shall specifically examine in such study the relationship between payments under such plans and payments made to hospitals under title XVIII of such Act, and the financial condition of hospitals receiving payments under such plans, with particular attention to hospitals in urban areas which treat large numbers of individuals eligible for medical assistance under title XIX of such Act and other low-income individuals.

(B) **REPORT.**—By not later than October 1, 1991, the Commission shall submit a report to Congress on the study conducted under subparagraph (A) and shall include in such report such recommendations relating to requirements for

payments to hospitals under title XIX of such Act as the Commission deems appropriate.

(5) **EFFECTIVE DATE.**—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(h) **PROVISIONS RELATING TO GEOGRAPHIC CLASSIFICATION OF HOSPITALS.**—

(1) **PAYMENTS TO RECLASSIFIED HOSPITALS.**—

(A) **IN GENERAL.**—Section 1886(d)(8)(C) (42 U.S.C. 1395ww(d)(8)(C)) is amended—

(i) in clause (i), in the matter preceding subclause (I), by striking “area—” and inserting “area, or by treating hospitals located in one urban area as being located in another urban area—”;

(ii) by amending clause (i)(II) to read as follows:

“(II) reduces the wage index for that urban area by more than 1 percentage point (as applied under this subsection), the Secretary shall calculate and apply such wage index under this subsection separately to hospitals located in such urban area (excluding all the hospitals so treated) and to the hospitals so treated (as if such hospitals were located in such urban area).”;

(iii) by striking clause (ii); and

(iv) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii).

(B) **EFFECTIVE DATE.**—The amendments made by subparagraph (A) shall apply to discharges occurring on or after January 1, 1991.

(2) **GEOGRAPHIC CLASSIFICATION REVIEW BOARD.**—

(A) **DEADLINE FOR SUBMISSION OF APPLICATIONS.**—For purposes of determining whether a hospital requesting a change in geographic classification for fiscal year 1992 under section 1886(d)(10) of the Social Security Act has met the deadline described in subparagraph (C)(ii) of such section, an application submitted under such subparagraph shall be considered to have been submitted by the first day of the preceding fiscal year if it is submitted within 60 days of the date of publication of the guidelines described in subparagraph (D)(i) of such section.

(B) **TECHNICAL CORRECTIONS.**—Section 1886(d)(10) (42 U.S.C. 1395ww(d)(10)) is amended—

(i) in subparagraph (A), by striking “Geographical” and inserting “Geographic”;

(ii) in subparagraph (B)(i)—

(I) by striking “representatives” and inserting “representative”, and

(II) by striking “1 member shall be a member of the Prospective Payment Assessment Commission, and at least”;

(iii) in subparagraph (B)(ii), by striking “all” and inserting “initial”; and

(iv) in subparagraph (10)(C)(iii)(II)—

(I) by striking the first 2 sentences and inserting the following: “Appeal of decisions of the Board shall be subject to the provisions of section 557b of title 5, United States Code.”, and

(II) by striking "after" and inserting "after the date on which".

SEC. 4003. EXPANSION OF DRG PAYMENT WINDOW.

(a) **IN GENERAL.**—The first sentence of section 1886(a)(4) (42 U.S.C. 1395ww(a)(4)) is amended by striking the period and inserting the following: ", and includes the costs of all services for which payment may be made under this title that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to the patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply—

(1) in the case of any services provided during the day immediately preceding the date of a patient's admission (without regard to whether the services are related to the admission), to services furnished on or after the date of the enactment of this Act and before October 1, 1991;

(2) in the case of diagnostic services (including clinical diagnostic laboratory tests), to services furnished on or after January 1, 1991; and

(3) in the case of any other services, to services furnished on or after October 1, 1991.

(c) **ISSUANCE OF INTERIM FINAL REGULATION.**—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this section.

SEC. 4004. PAYMENTS FOR MEDICAL EDUCATION COSTS.

(a) **HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part A of title XVIII of the Social Security Act due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h).

(2) **CAP ON ANNUAL AMOUNT OF RECOUPMENT.**—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

(3) **EFFECTIVE DATE.**—Paragraphs (1) and (2) shall take effect October 1, 1990.

(b) **UNIVERSITY HOSPITAL NURSING EDUCATION.**—

(1) **IN GENERAL.**—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part A of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

(2) **CONDITIONS FOR REIMBURSEMENT.**—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the cost reporting period described in subparagraph (A);

(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

(3) **PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.**—

(A) **IN GENERAL.**—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part A of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act).

(B) **REFUND OF AMOUNTS RECOUPED.**—If, prior to the date of the enactment of this Act, the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part A of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

(4) **SPECIAL AUDIT TO DETERMINE COSTS.**—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

(5) **EFFECTIVE DATE.**—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990.

SEC. 4005. PPS-EXEMPT HOSPITALS.

(a) **ADJUSTMENT TO PAYMENT AMOUNTS.**—

(1) **IN GENERAL.**—Section 1886(b)(1)(B) (42 U.S.C. 1395ww(b)(1)(B)) is amended by striking "(ii) in the case of" and

all that follows through the semicolon and inserting the following: "(ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs exceed the target amount (except that such additional amount may not exceed 10 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;"

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after October 1, 1991.

(b) DEVELOPMENT OF NATIONAL PROSPECTIVE PAYMENT RATES FOR CURRENT NON-PPS HOSPITALS.—

(1) **DEVELOPMENT OF PROPOSAL.**—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act) receive payment for the operating and capital-related costs of inpatient hospital services under part A of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of nationally-determined average standardized amounts. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program;

(B) provide for adjustments to prospectively determined rates to account for changes in a hospital's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, costs related to graduate medical education programs, differences in wages and wage-related costs among hospitals located in various geographic areas, and other factors the Secretary considers appropriate; and

(E) provide for the appropriate allocation of operating and capital-related costs of hospitals not subject to the new prospective payment system and distinct units of such hospitals that would be paid under such system.

(2) **REPORTS.**—(A) By not later than April 1, 1992, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than June 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(c) APPEALS OF TARGET AMOUNTS.—

(1) DEADLINES FOR REVIEW AND DECISION.—(A) Section 1816(f) (42 U.S.C. 1395h(f)) is amended—

(i) by striking “(1)” and “(2)” and inserting “(A)” and “(B)”;

(ii) by striking “(f)” and inserting “(f)(1)”;

(iii) by striking “Such standards and criteria” and all that follows and inserting the following:

“(2) The standards and criteria established under paragraph (1) shall include—

“(A) with respect to claims for services furnished under this part by any provider of services other than a hospital—

“(i) whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days, and

“(ii) the extent to which such agency or organization’s determinations are reversed on appeal; and

“(B) with respect to applications for an exemption from or exception or adjustment to the target amount applicable under section 1886(b) to a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B))—

(i) if such agency or organization receives a completed application, whether such agency or organization is able to process such application not later than 75 days after the application is filed, and

“(ii) if such agency or organization receives an incomplete application, whether such agency or organization is able to return the application with instructions on how to complete the application not later than 60 days after the application is filed.”

(B) Section 1886(b)(4)(A) (42 U.S.C. 1395ww(b)(4)(A)) is amended by adding at the end the following new sentence: “The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.”

(2) STANDARDS FOR ASSIGNMENT OF NEW BASE PERIOD.—Section 1886(b)(4) (42 U.S.C. 1395ww(b)(4)) is amended—

(A) by redesignating subparagraph (B) as subparagraph (C); and

(B) by inserting after subparagraph (A) the following new subparagraph:

“(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration—

“(i) changes in applicable technologies and medical practices, or differences in the severity of illness among patients, that increase the hospital’s costs;

“(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

“(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital’s costs of providing in-patient services.”

(3) **GUIDANCE TO INTERMEDIARIES AND HOSPITALS.**—The Administrator of the Health Care Financing Administration shall provide guidance to agencies and organizations performing functions pursuant to section 1816 of the Social Security Act and to hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of such Act) to assist such agencies, organizations, and hospitals in filing complete applications with the Administrator for exemptions, exceptions, and adjustments under section 1886(b)(4)(A) of such Act.

(4) **EFFECTIVE DATES.**—The amendments made by paragraph (1) shall take effect on the date of the enactment of this Act, and the amendments made by paragraph (2) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

SEC. 4006. HOSPICE BENEFIT EXTENSION.

(a) **IN GENERAL.**—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(4), by striking “90 days each” and all that follows through “with respect to”, and inserting the following: “90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to”; and

(2) in subsection (d)—

(A) in paragraph (1), by striking “90 days each” and all that follows through “lifetime” and inserting the following: “90 days each, a subsequent period of 30 days, and a subsequent extension period during the individual’s lifetime”, and

(B) in paragraph (2)(B), by striking “a 90- or 30-day period,” and inserting “a 90- or 30-day period or a subsequent extension period.”

(b) **CONFORMING AMENDMENT.**—Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(1) in clause (i), by striking “and” at the end;

(2) in clause (ii), by striking the semicolon at the end and inserting “, and”; and

(3) by adding at the end the following new clause:

“(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;”

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to care and services furnished on or after January 1, 1990.

SEC. 4007. FREEZE IN PAYMENTS UNDER PART A THROUGH DECEMBER 31.

(a) **IN GENERAL.**—Notwithstanding any other provision of law, for purposes of determining the amount of payment for items or services under part A of title XVIII of the Social Security Act (including payments under section 1886 of such Act attributable to or allocated under such part) during the period described in subsection (b):

(1) The market basket percentage increase (described in section 1886(b)(3)(B)(iii) of the Social Security Act) shall be deemed to be 0 for discharges occurring during such period.

(2) The percentage increase or decrease in the medical care expenditure category of the consumer price index applicable under section 1814(i)(2)(B) of such Act shall be deemed to be 0.

(3) The area wage index applicable to a subsection (d) hospital under section 1886(d)(3)(E) of such Act shall be deemed to be the area wage index applicable to such hospital as of September 30, 1990.

(4) The percentage change in the consumer price index applicable under section 1886(h)(2)(D) of such Act shall be deemed to be 0.

(b) **DESCRIPTION OF PERIOD.**—The period referred to in subsection (a) is the period beginning on October 21, 1990, and ending on December 31, 1990.

SEC. 4008. MISCELLANEOUS AND TECHNICAL PROVISIONS RELATING TO PART A.

(a) **WAIVER OF LIABILITY FOR SKILLED NURSING FACILITIES AND HOSPICES.**—

(1) **SKILLED NURSING FACILITIES.**—The second sentence of section 9126(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking “October 31, 1990” and inserting “December 31, 1995”.

(2) **HOSPICES.**—Section 9305(f)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking “November 1, 1990” and inserting “December 31, 1995”.

(3) **EFFECTIVE DATE.**—The amendments made by paragraphs (1) and (2) shall take effect on the date of the enactment of this Act.

(b) **HOSPITAL OBLIGATIONS WITH RESPECT TO TREATMENT OF EMERGENCY MEDICAL CONDITIONS.**—

(1) **CIVIL MONETARY PENALTIES.**—Section 1867(d)(2)(A) (42 U.S.C. 1395dd(d)(2)(A)) is amended by striking “knowingly” and inserting “negligently”.

(2) **APPLICATION OF PENALTIES TO SMALL HOSPITALS.**—Section 1867(d)(2)(A) (42 U.S.C. 1395dd(d)(2)(A)) is amended by inserting “(or not more than \$25,000 in the case of a hospital with less than 100 beds)” after “\$50,000”.

(3) **TERMINATION OF HOSPITAL PROVIDER AGREEMENTS.**—

(A) Section 1867 (42 U.S.C. 1395dd) is further amended—

(i) by striking paragraph (1) of subsection (d),

(ii) by redesignating paragraphs (2) and (3) of subsection (d) as paragraph (1) and (2), respectively, and

(iii) in subsection (c)(2)(C), by striking “(d)(2)(C)” and inserting “(d)(1)(C)”.

(B) Section 1866(a)(1)(I)(i) (42 U.S.C. 1395cc(a)(1)(I)(i)) is amended by inserting "and to meet the requirements of such section" before the comma at the end.

(4) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act.

(c) **INSPECTOR GENERAL STUDY OF PROHIBITION ON HOSPITAL EMPLOYMENT OF PHYSICIANS.**—

(1) **STUDY.**—The Secretary of Health and Human Services (acting through the Inspector General of the Department of Health and Human Services) shall conduct a study of the effect of State laws prohibiting the employment of physicians by hospitals on the availability and accessibility of trauma and emergency care services, and shall include in such study an analysis of the effect of such laws on the ability of hospitals to meet the requirements of section 1867 of the Social Security Act relating to the examination and treatment of individuals with an emergency medical condition and women in labor.

(2) **REPORT.**—By not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1).

(d) **DESIGNATION OF RURAL PRIMARY CARE HOSPITALS.**—

(1) **PRIORITY DESIGNATIONS OF BORDER STATE HOSPITALS.**—Section 1820(i)(2)(C) (42 U.S.C. 1395i-4(i)(2)(C)) is amended by adding at the end the following new sentence: "In designating facilities as rural primary care hospitals under this subparagraph, the Secretary shall give preference to facilities not meeting the requirements of clause (i) of subparagraph (A) that have entered into an agreement described in subsection (g)(2) with a rural health network located in a State receiving a grant under subsection (a)(1)."

(2) **ELIGIBILITY OF CERTAIN CLOSED HOSPITALS.**—Section 1820(f)(1)(B) (42 U.S.C. 1395i-4(f)(1)(B)) is amended by striking "is a hospital," and inserting the following: "is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed),"

(3) **ELIGIBILITY OF URBAN HOSPITALS.**—Section 1820(f)(1)(A) (42 U.S.C. 1395i-4(f)(1)(A)) is amended by striking the semicolon and inserting the following: "; or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas;"

(4) **EFFECTIVE DATE.**—The amendments made by paragraphs (1), (2), and (3) shall take effect on the date of the enactment of this Act.

(e) **SKILLED NURSING FACILITY ROUTINE COST LIMITS.**—

(1) **IN GENERAL.**—Section 6024 of the Omnibus Budget Reconciliation Act of 1989 is amended by adding at the end the following new sentence: "The Secretary shall update such costs under such section for cost reporting periods beginning on or after October 1, 1989, by using cost reports submitted by skilled

nursing facilities for cost reporting periods ending not earlier than January 31, 1988, and not later than December 31, 1988.”.

(2) 2-YEAR UPDATES REQUIRED.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended in the matter following paragraph (4) by striking the period and inserting the following: “, and shall, for cost reporting periods beginning on or after October 1, 1992 and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection”.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

(f) CLARIFICATION OF EXTENSION OF WAIVER FOR FINGER LAKES AREA HOSPITAL CORPORATION.—

(1) IN GENERAL.—The second sentence of section 1886(c)(4) (42 U.S.C. 1395ww(c)(4)) is amended by striking “rate of increase from” and inserting “payments under the State system as compared to aggregate payments which would have been made under the national system since”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

(g) ENROLLMENT IN PART A FOR HMO MEMBERS.—

(1) IN GENERAL.—Section 1818(c) (42 U.S.C. 1395i-2(c)) is amended—

(A) by striking “and” at the end of paragraph (5),

(B) by striking the period at the end of paragraph (6) and inserting a semicolon, and

(C) by adding at the end the following new paragraphs:

“(7) an individual who meets the conditions of subsection (a) may enroll under this part during a special enrollment period that includes any month during any part of which the individual is enrolled under section 1876 with an eligible organization and ending with the last day of the 8th consecutive month in which the individual is at no time so enrolled;

“(8) in the case of an individual who enrolls during a special enrollment period under paragraph (7)—

“(A) in any month of the special enrollment period in which the individual is at any time enrolled under section 1876 with an eligible organization or in the first month following such a month, the coverage period shall begin on the first day of the month in which the individual so enrolls (or, at the option of the individual, on the first day of any of the following three months), or

“(B) in any other month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls; and

“(9) in applying the provisions of section 1839(b), there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled under section 1876 with an eligible organization.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on February 1, 1991.

(h) *NURSING HOME REFORM.*—(1) *NURSE AIDE TRAINING AND COMPETENCY EVALUATION.*—

(A) *NO COMPLIANCE ACTIONS BEFORE EFFECTIVE DATE OF GUIDELINES.*—The Secretary of Health and Human Services may not refuse to enter into an agreement or cancel an existing agreement with a State under section 1864 of the Social Security Act on the basis that the State failed to meet the requirement of section 1819(e)(1)(A) of such Act before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1819(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date.

(B) *PART-TIME NURSE AIDES NOT ALLOWED DELAY IN TRAINING.*—Section 1819(b)(5)(A) (42 U.S.C. 1396r(b)(5)(A)) is amended—

(i) by striking “A skilled nursing facility” and inserting “(i) Except as provided in clause (ii), a skilled nursing facility”;

(ii) by striking “(on a full-time, temporary, per diem, or other basis) and inserting “on a full-time basis”;

(iii) by striking “(i)” and “(ii)” and inserting “(I)” and “(II)”;

(iv) by adding at the end the following:

“(ii) A skilled nursing facility must not use on a temporary, per diem, leased, or on any basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).”

(C) *REQUIREMENT TO OBTAIN INFORMATION FROM NURSE AIDE REGISTRY.*—Section 1819(b)(5)(C) (42 U.S.C. 1395i-3(b)(5)(C)) is amended by striking “the State registry established under subsection (e)(2)(A) as to information in the registry” and inserting “any State registry established under subsection (e)(2)(A) that the facility believes will include information”.

(D) *RETRAINING OF NURSE AIDES.*—Section 1819(b)(5)(D) (42 U.S.C. 1395i-3(b)(5)(D)) is amended by striking the period at the end and inserting “, or a new competency evaluation program.”

(E) *CLARIFICATION OF NURSE AIDES NOT SUBJECT TO CHARGES.*—Section 1819(f)(2)(A)(iv) (42 U.S.C. 1395i-3(f)(2)(A)(iv)) is amended—

(i) in subclause (I), by striking “and” at the end;

(ii) in subclause (II), by inserting after “nurse aide” the following: “who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program”;

(iii) in subclause (II), by striking the period at the end and inserting “, and”;

(iv) by adding at the end the following new subclause:

“(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has re-

ceived an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.”.

(F) MODIFICATION OF NURSING FACILITY DEFICIENCY STANDARDS.—

(i) **IN GENERAL.**—Section 1819(f)(2)(B)(iii)(I) (42 U.S.C. 1395i-3(f)(2)(B)(iii)(I)) is amended to read as follows:

“(I) offered by or in a skilled nursing facility which, within the previous 2 years—

“(a) has operated under a waiver under subsection (b)(4)(C)(ii)(II);

“(b) has been subject to an extended (or partial extended) survey under subsection (g)(2)(B)(i) or section 1919(g)(2)(B)(i); or

“(c) has been assessed a civil money penalty described in subsection (h)(2)(B)(ii) or section 1919(h)(2)(A)(ii) of not less than \$5,000, or has been subject to a remedy described in clauses (i) or (iii) of subsection (h)(2)(B), subsection (h)(4), section 1919(h)(1)(B)(i), or in clauses (i), (iii), or (iv) of section 1919(h)(2)(A), or”.

(ii) **EFFECTIVE DATE.**—The amendments made by clause (i) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

(I) had its participation terminated under title XVIII of the Social Security Act or under the State plan under title XIX of such Act;

(II) was subject to a denial of payment under either such title;

(III) was assessed a civil money penalty not less than \$5,000 for deficiencies in nursing facility standards;

(IV) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

(V) pursuant to State action, was closed or had its residents transferred.

(G) CLARIFICATION OF STATE RESPONSIBILITY TO DETERMINE COMPETENCY.—Section 1819(f)(2)(B) (42 U.S.C. 1395i-3(f)(2)(B)) is amended in the second sentence by inserting “(through subcontract or otherwise)” after “may not delegate”.

(H) EFFECTIVE DATE.—Except as provided in subparagraph (F), the amendments made by this subsection shall

take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(2) OTHER AMENDMENTS.—

(A) ASSURANCE OF APPROPRIATE PAYMENT AMOUNTS.—(i) Section 1861(v)(1)(E) (42 U.S.C. 1395x(v)(1)(E)) is amended in the second sentence by striking “the costs of such facilities” and inserting “the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) of such facilities”.

(ii) Section 1888(d)(1) (42 U.S.C. 1395xx(d)(1)) is amended in the first sentence by striking “(and capital-related costs)” and inserting “(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) and capital-related costs”.

(B) DISCLOSURE OF INFORMATION OF QUALITY ASSESSMENT AND ASSURANCE COMMITTEES.—Section 1819(b)(1)(B) (42 U.S.C. 1395i-3(b)(1)(B)) is amended by adding at the end the following new sentence: “A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.”.

(C) PERIOD FOR RESIDENT ASSESSMENT.—Section 1819(b)(3)(C)(i)(I) (42 U.S.C. 1395i-3(b)(3)(C)(i)(I)) is amended by striking “4 days” and inserting “not later than 14 days”.

(D) CLARIFICATION OF RESPONSIBILITY FOR SERVICES FOR MENTALLY ILL AND MENTALLY RETARDED RESIDENTS.—Section 1819(b)(4)(A) (42 U.S.C. 1395i-3(b)(4)(A)) is amended—

(i) by striking “and” at the end of clause (v),

(ii) by striking the period at the end of clause (vi) and inserting “; and”, and

(iii) by inserting after clause (vi) the following new clause:

“(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.”.

(E) NOTIFICATION OF SECRETARIAL WAIVER.—Section 1819(b)(4)(C)(ii) (42 U.S.C. 1395i-3(b)(4)(C)(ii)) is amended—

(i) by striking “and” at the end of subclause (II);

(ii) by striking the period at the end of subclause (III) and inserting a comma; and

(iii) by adding at the end the following new subclauses:

“(IV) the Secretary provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

“(V) the facility that is granted such a waiver notifies residents of the facility (or, where appro-

priate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.”

(F) **CLARIFICATION OF DEFINITION OF NURSE AIDE.**—Section 1819(b)(5)(F)(i) (42 U.S.C. 1395i-3(b)(5)(F)(i)) is amended by striking “(G)),” and inserting “(G)) or a registered dietitian,”

(G) **RESIDENTS’ RIGHTS TO REFUSE INTRA-FACILITY TRANSFERS FOR NON-MEDICAL REASONS.**—Section 1819(c)(1)(A) (42 U.S.C. 1395i-3(c)(1)(A)) is amended—

(i) by redesignating clause (x) as clause (xi) and by inserting after clause (ix) the following new clause:

“(x) **REFUSAL OF CERTAIN TRANSFERS.**—The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility (for purposes of this title) to a portion of the facility that is not such a skilled nursing facility.”; and

(B) by adding at the end the following: “A resident’s exercise of a right to refuse transfer under clause (x) shall not affect the resident’s eligibility or entitlement to benefits under this title or to medical assistance under title XIX of this Act.”

(H) **RESIDENT ACCESS TO CLINICAL RECORDS.**—Section 1819(c)(1)(A)(iv) (42 U.S.C. 1395i-3(c)(1)(A)(iv)) is amended by inserting before the period at the end the following: “and to access to current clinical records of the resident upon request by the resident or the resident’s legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request”.

(I) **INCLUSION OF STATE NOTICE OF RIGHTS IN FACILITY NOTICE OF RIGHTS.**—Section 1819(c)(1)(B)(ii) (42 U.S.C. 1395i-3(c)(1)(B)(ii)) is amended by inserting “including the notice (if any) of the State developed under section 1919(e)(6)” after “in such rights”.

(J) **SPECIFICATION OF REQUIRED PROGRAMS.**—Section 1819(e)(1)(A) (42 U.S.C. 1395i-3(e)(1)(A)) is amended by striking “clause (i) or (ii) of subsection (f)(2)(A)” and inserting “subsection (f)(2)”.

(K) **CLARIFICATION OF NURSE AIDE REGISTRY REQUIREMENTS.**—Section 1819(e)(2) (42 U.S.C. 1395i-3(e)(2)) is amended—

(i) in subparagraph (A), by striking the period and inserting the following: “; or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.”; and

(ii) by adding at the end the following new subparagraph:

“(C) **PROHIBITION AGAINST CHARGES.**—A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).”.

(L) **CLARIFICATION ON FINDINGS OF NEGLECT.**—Section 1819(g)(1)(C) (42 U.S.C. 1395i-3(g)(1)(C)) is amended by

adding at the end the following: "A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual."

(M) **TIMING OF PUBLIC DISCLOSURE OF SURVEY RESULTS.**—Section 1819(g)(5)(A)(i) (42 U.S.C. 1395i-3(g)(5)(A)(i)) is amended by striking "deficiencies and plans" and inserting "deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans".

(N) **OMBUDSMAN PROGRAM COORDINATION WITH STATE SURVEY AND CERTIFICATION AGENCIES.**—Section 1819(g)(5)(B) (42 U.S.C. 1395i-3(g)(5)(B)) is amended by striking "with respect" and inserting "or of any adverse action taken against a skilled nursing facility under paragraphs (1), (2), or (4) of subsection (h), with respect".

(O) **MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES.**—Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 with respect to services described in clauses (ii), (iv), and (v) of section 1819(b)(4)(A) of the Social Security Act shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987.

(P) **EFFECTIVE DATES.**—The amendments made by this paragraph shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(i) **CLARIFICATION OF SECRETARIAL WAIVER AUTHORITY.**—

(1) **RURAL HOSPITAL DEMONSTRATION.**—The Secretary of Health and Human Services is authorized to waive such provisions of title XVIII of the Social Security Act as are necessary to conduct any demonstration project for limited-service rural hospitals with respect to which the Secretary has entered into an agreement before the date of the enactment of the Omnibus Budget Reconciliation Act of 1989.

(2) **NURSING HOME DEMONSTRATIONS.**—Section 6901(d)(3)(B) of the Omnibus Budget Reconciliation Act of 1989 is amended—

(A) by striking "Wisconsin" and inserting "Wisconsin and nursing home case-mix demonstration projects in other States"; and

(B) by striking the second sentence.

(3) **STATE WAIVER AUTHORITY.**—Section 1814(b) (42 U.S.C. 1395f(b)) is amended—

(A) in paragraph (3)(B), by striking "October 1, 1983" and inserting "January 1, 1981";

(B) in the second sentence, by striking "seventh month" and inserting "37th month"; and

(C) by adding at the end the following: "If, by the end of such 36-month period, the Secretary determines, based on evidence submitted by the Governor of the State, that neither of the conditions described in subparagraph (A) or (B)

of paragraph (3) continues to apply, the Secretary shall continue without interruption payment to hospitals in the State under the State's system. If, by the end of such 36-month period, the Secretary determines, based on such evidence, that either of the conditions described in subparagraph (A) or (B) of such paragraph continues to apply, the Secretary shall (i) collect any net excess reimbursement to hospitals in the State during such 36-month period (basing such net excess reimbursement on the net difference, if any, in the rate of increase in costs per hospital inpatient admission under the State system compared to the rate of increase in such costs with respect to all hospitals in the United States over the 36-month period, as measured by including the cumulative savings under the State system based on the difference in the rate of increase in costs per hospital inpatient admission under the State system as compared to the rate of increase in such costs with respect to all hospitals in the United States between January 1, 1981, and the date of the Secretary's initial notice), and (ii) provide a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system."

(4) **EFFECTIVE DATE.**—The amendment made by paragraphs (1) and (2) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

(j) **DETERMINATION OF REASONABLE COSTS RELATING TO SWING BEDS.**—

(1) **IN GENERAL.**—Section 1883(a)(2)(B) (ii)(II) (42 U.S.C. 1395tt(a)(2)(B)(ii)(II)) is amended by striking "the previous calendar year" and all that follows through the period and inserting "the most recent year for which cost reporting data are available with respect to such services (increased in a compounded manner by the applicable increase for payments for routine service costs of skilled nursing facilities under section 1888 for subsequent cost reporting periods and up to and including such calendar year) under this title to freestanding skilled nursing facilities in the region (as defined in section 1886(d)(2)(D)) in which the facility is located."

(2) **HOLD HARMLESS.**—If, as a result of the amendment made by paragraph (1), the reasonable cost of routine services furnished by a hospital during a calendar year (as determined under section 1883 of the Social Security Act) is less than the reasonable cost of such services determined under such section for the previous calendar year, the reasonable cost of such services furnished by the hospital during the calendar year under such section shall be equal to the reasonable cost determined under such section for the previous calendar year.

(3) **SWING BEDS CERTIFIED PRIOR TO MAY 1, 1987.**—Notwithstanding the requirement of section 1883(b)(1) of the Social Security Act that the Secretary may not enter into an agreement under such section with a hospital that is not located in a rural area, any agreement entered into under such section on or before May 1, 1987, between the Secretary of Health and Human Serv-

ices and a hospital located in an urban area shall remain in effect.

(4) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 1990.

(k) **PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITY SERVICES.**—

(1) **DEVELOPMENT OF PROPOSAL.**—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under part A of the medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program without jeopardizing access to extended care services for individuals unable to care for themselves;

(B) provide for adjustments to prospectively determined rates to account for changes in a facility's case mix, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, differences in wages and wage-related costs among facilities located in various geographic areas, and other factors the Secretary considers appropriate; and

(E) take into consideration the appropriateness of classifying patients and payments upon functional disability, cognitive impairment, and other patient characteristics.

(2) **REPORTS.**—(A) By not later than April 1, 1991, the Secretary (acting through the Administrator of the Health Care Financing Administration) shall submit any research studies to be used in developing the proposal under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than September 1, 1991, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(C) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(1) REVIEW OF HOSPITAL REGULATIONS WITH RESPECT TO RURAL HOSPITALS.—

(1) *IN GENERAL.*—The Secretary of Health and Human Services shall review the requirements applicable under title XVIII of the Social Security Act to determine which requirements could be made less administratively and economically burdensome (without diminishing the quality of care) for hospitals defined in section 1886(d)(1)(B) of such Act that are located in a rural area (as defined in section 1886(d)(2)(D) of such Act). Such review shall specifically include standards related to staffing requirements.

(2) *REPORT.*—The Secretary of Health and Human Services shall report to Congress by April 1, 1992, on the results of the review conducted under subsection (a), and include conclusions on which regulations, if any, should be modified with respect to hospitals described in subsection (a).

(m) MISCELLANEOUS TECHNICAL CORRECTIONS.—

(1) *APPLICATION OF PREENTITLEMENT PSYCHIATRIC HOSPITAL SERVICES TO LIMIT ON INPATIENT HOSPITAL SERVICES.*—Effective as if included in the enactment of the Medicare Catastrophic Coverage Repeal Act of 1989, section 101(b)(1)(B) is amended by inserting “(other than the limitation under section 1812(c) of such Act)” after “limitation”.

(2) PROVISIONS RELATING TO HOSPITALS.—

(A) Section 1886(d)(5)(D)(iii) (42 U.S.C. 1395ww(d)(5)(D)(iii)), as amended by section 6003(e)(1)(A)(iv) of Omnibus Budget Reconciliation Act of 1989 (in this subsection referred to as “OBRA-1989”), is amended by striking “The term” and inserting “For purposes of this title, the term”.

(B) Section 1820 of such Act (42 U.S.C. 1395i-4), as added by section 6003(g)(1)(A) of the Omnibus Budget Reconciliation Act of 1989, is amended—

(i) in subsection (d)(1), by striking “demonstration”;

(ii) in subsection (g)(1)(A)(ii), by striking “rural referral center” and inserting “regional referral center”; and

(iii) in subsection (j), by inserting “and part C” after “this part”.

(C) Section 6003(g)(3)(C)(vii)(I) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking “each place it appears”.

(D) Section 1835(c) of the Social Security Act (42 U.S.C. 1395n(c)) is amended—

(i) in the first sentence, by striking “a hospital” and inserting “a hospital or a rural primary care hospital”;

(ii) in the second sentence, by striking “1833(a)(2)” and inserting “1833(a)(2) (or, in the case of a rural primary care hospital, in accordance with section 1833(a)(6))”; and

(iii) by striking the third sentence.

(3) TECHNICAL CORRECTIONS RELATING TO OTHER PROVIDERS OF SERVICES.—

(A) Section 1814(i)(1)(C)(i) (42 U.S.C. 1395f(i)(1)(C)(i)), as amended by section 6005(a)(2) of the Omnibus Budget Reconciliation Act of 1989, is amended by striking "during fiscal year 1990" and inserting "on or after January 1, 1990, and on or before September 30, 1990,".

(B) Section 6005(c) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking "subsection (a)" and inserting "subsections (a) and (b)".

(C) Section 1818A(d)(1) (42 U.S.C. 1395i-2a(d)(1)), as inserted by section 6012(a)(2) of the Omnibus Budget Reconciliation Act of 1989, is amended—

(i) in subparagraph (A), by inserting "for enrollment under this section" after "Premiums", and

(ii) by striking subparagraph (C).

(D) Section 1818(g)(2)(B) (42 U.S.C. 1395i-2(g)(2)(B)), as added by section 6013(a) of the Omnibus Budget Reconciliation Act of 1989, is amended by striking "subsection (c)" and inserting "subsection (c)(6)".

(F) Section 1819(f)(2)(A)(ii) (42 U.S.C. 1395i-3(f)(2)(A)(ii)) is amended by striking "and" at the end.

(G) Section 1866(a)(1)(F) (42 U.S.C. 1395cc(a)(1)(F)) is amended—

(i) in clause (i), by striking the comma at the end and inserting ")," and

(ii) in clause (ii), by striking "(4)(A)" and inserting "(3)(A)" and by striking the semicolon at the end and inserting a comma.

PART 2—PROVISIONS RELATING TO PART B

Subpart A—Payment for Physicians' Services

SEC. 4101. CERTAIN OVERVALUED PROCEDURES.

(a) PREVIOUSLY IDENTIFIED PROCEDURES.—Section 1842(b)(14) (42 U.S.C. 1395u(b)(14)) is amended—

(1) by inserting "(i)" after "(14)(A)"; and

(2) by adding at the end of subparagraph (A) the following new clause:

"(ii) In determining the reasonable charge for a physicians' service specified in subparagraph (C)(i) and furnished during 1991, the prevailing charge for such service shall be the prevailing charge otherwise recognized for such service for the period during 1990 beginning on April 1, reduced by the same amount as the amount of the reduction effected under this paragraph (as amended by the Omnibus Budget Reconciliation Act of 1990) for such service during such period."

(b) UNSURVEYED SURGICAL AND TECHNICAL PROCEDURES.—(1) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

"(16)(A) In determining the reasonable charge for all physicians' services other than physicians' services specified in subparagraph (B) furnished during 1991, the prevailing charge for a locality shall

be 6.5 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

“(B) For purposes of subparagraph (A), the physicians’ services specified in this subparagraph are as follows:

“(i) Radiology, anesthesia and physician pathology services, the technical components of diagnostic tests specified in paragraph (17) and physicians’ services specified in paragraph (14)(C)(i).

“(ii) Primary care services specified in subsection (i)(4), hospital inpatient medical services, consultations, other visits, preventive medicine visits, psychiatric services, emergency care facility services, and critical care services.

“(iii) Partial, simple and subcutaneous mastectomy; tendon sheath injections; small joint arthrocentesis; femoral fracture treatments; trochanteric fracture treatments; endotracheal intubation; thoracentesis; thoracostomy; lobectomy; aneurysm repair; enterectomy; colectomy; cholecystectomy; cystourethroscopy; transurethral fulguration; transurethral resection; sacral laminectomy; tympanoplasty with mastoidectomy; and ophthalmoscopy.”

(2) In applying section 1842(b)(16) of the Social Security Act:

(A) The codes for the procedures specified in clause (ii) are as follows: Hospital inpatient medical services (HCPCS codes 90200 through 90292), consultations (HCPCS codes 90600 through 90654), other visits (HCPCS code 90699), preventive medicine visits (HCPCS codes 90750 through 90764), psychiatric services (HCPCS codes 90801 through 90862), emergency care facility services (HCPCS codes 99062 through 99065), and critical care services (HCPCS codes 99160 through 99174).

(B) The codes for the procedures specified in clause (iii) are as follows: Partial, simple and subcutaneous mastectomy (HCPCS codes 19160 and 19162); tendon sheath injections and small joint arthrocentesis (HCPCS codes 20550, 20600, 20605, and 20610); femoral fracture and trochanteric fracture treatments (HCPCS codes 27230, 27232, 27234, 27238, 27240, 27242, 27246, and 27248); endotracheal intubation (HCPCS code 31500); thoracentesis (HCPCS code 32000); thoracostomy (HCPCS codes 32020, 32035, and 32036); aneurysm repair (HCPCS codes 35111); cystourethroscopy (HCPCS code 52340); transurethral fulguration and resection (HCPCS codes 52606 and 52620); tympanoplasty with mastoidectomy (HCPCS code 69645); and ophthalmoscopy (HCPCS codes 92250, and 92260).”

SEC. 4102. RADIOLOGY SERVICES.

(a) REDUCTION IN FEE SCHEDULE.—Section 1834(b)(4) (42 U.S.C. 1395m(b)(4)) is amended—

(1) by redesignating subparagraphs (D) and (E) as subparagraphs (E) and (F), respectively, and

(2) by inserting after subparagraph (C) the following new subparagraph:

“(D) 1991 FEE SCHEDULES.—For radiologist services (other than portable X-ray services) furnished under this part during 1991, the conversion factors used in a locality under this subsection shall be determined as follows:

"(i) **NATIONAL WEIGHTED AVERAGE CONVERSION FACTOR.**—The Secretary shall estimate the national weighted average of the conversion factors used under this subsection for services furnished during 1990 beginning on April 1, using the best available data.

"(ii) **REDUCED NATIONAL WEIGHTED AVERAGE.**—The national weighted average estimated under clause (i) shall be reduced by 13 percent.

"(iii) **COMPUTATION OF 1990 LOCALITY INDEX RELATIVE TO NATIONAL AVERAGE.**—The Secretary shall establish an index which reflects, for each locality, the ratio of the conversion factor used in the locality under this subsection to the national weighted average estimated under clause (i).

"(iv) **LOCAL ADJUSTMENT.**—Subject to clause (vii), the conversion factor to be applied to the professional or technical component of a service in a locality is the sum of $\frac{1}{2}$ of the locally-adjusted amount determined under clause (v) and $\frac{1}{2}$ of the GPCI-adjusted amount determined under clauses (vi).

"(v) **LOCALLY-ADJUSTED AMOUNT.**—For purposes of clause (iv), the locally adjusted amount determined under this clause is the product of (I) the national weighted average conversion factor computed under clause (ii), and (II) the index value established under clause (iii) for the locality.

"(vi) **GPCI-ADJUSTED AMOUNT.**—For purposes of clause (iv), the GPCI-adjusted amount determined under this clause is the sum of—

"(I) the product of (a) the portion of the reduced national weighted average conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238–36243)); and

"(II) the product of (a) the remaining portion of the reduced national weighted average conversion factor computed under clause (ii), and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause with respect to the professional component of a service, 80 percent of the conversion factor shall be considered to be attributable to physician work and with respect to the technical component of the service, 0 percent shall be considered to be attributable to physician work.

"(vii) **LIMITS ON CONVERSION FACTOR.**—The conversion factor to be applied to a locality under this subparagraph to the professional or technical component of a service shall not be more than 9.5 percent below the conversion factor applied in the locality under subparagraph (C) to such component, but in no case shall

the conversion factor be less than 60 percent of the national weighted average of the conversion factors (computed under clause (i)).”.

(b) **SPECIAL RULE FOR TRANSITION FOR RADIOLOGY SERVICES.**—Section 1848(a)(2)(C) (42 U.S.C. 1395w-4(a)(2)(C)) is amended—

(1) by inserting “AND RADIOLOGY” after “SPECIAL RULE FOR ANESTHESIA”, and

(2) by adding at the end the following: “With respect to radiology services, ‘109 percent’ and ‘9 percent’ shall be substituted for ‘115 percent’ and ‘15 percent’, respectively, in subparagraph (A)(ii).”

(c) **REDUCTION IN PREVAILING CHARGE LEVEL FOR OTHER RADIOLOGY SERVICES.**—

(1) **IN GENERAL.**—In applying part B of title XVIII of the Social Security Act, the prevailing charge for physicians’ services, furnished during 1991, which are radiology services may not exceed the fee schedule amount established under section 1834(b) of such Act with respect to such services.

(2) **EXCEPTION.**—Paragraph (1) shall not apply to radiology services which are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989.

(d) **REDUCTION IN PAYMENTS FOR TECHNICAL COMPONENTS OF CERTAIN SCANNING SERVICES.**—Section 1834(b)(4) (42 U.S.C. 1395m(b)(4)) is amended by inserting after subparagraph (D) the following new paragraph:

“(E) In the case of the technical components of magnetic resonance imaging (MRI) services and computer assisted tomography (CAT) services furnished after December 31, 1990, the amount otherwise payable shall be reduced by 10 percent.”.

(e) **LIMITATION ON ADJUSTMENTS.**—For radiologist services furnished during 1991 for which payment is made under section 1834(b) of the Social Security Act—

(1) a carrier may not make any adjustment, under section 1842(b)(3)(B) of such Act, in the payment amount for the service under section 1834(b) on the basis that the payment amount is higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier,

(2) no payment adjustment may be made under section 1842(b)(8) of such Act, and

(3) section 1842(b)(9) of such Act shall not apply.

(f) **USE OF LOCALITIES.**—Section 1834(b)(1)(B) (42 U.S.C. 1395m(b)(1)(B)) is amended by inserting “locality,” after “state-wide,”.

(g) **TREATMENT OF NUCLEAR MEDICINE PHYSICIANS.**—

(1) **CONTINUATION OF SPECIAL RULE.**—Section 6105(b) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking all that follows “Social Security Act” the second place it appears and inserting the following: “beginning April 1, 1990, and ending December 31, 1991, there shall be substituted for the fee schedule otherwise applicable a fee schedule based $\frac{1}{3}$ on the fee schedule computed under such section (without regard to

this subsection) and $\frac{2}{3}$ on 101 percent of the 1988 prevailing charge for such services.”.

(2) **ADJUSTED HISTORICAL PAYMENT BASIS.**—Section 1848(a)(2)(D) (42 U.S.C. 1395w-4(a)(2)(D)) is amended—

(A) in clause (ii) by inserting “, but excluding nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989” after “section 1834(b)(6))”, and

(B) by adding at the end the following:

“(iii) **NUCLEAR MEDICINE SERVICES.**—In applying clause (i) in the case of physicians’ services which are nuclear medicine services that are subject to section 6105(b) of the Omnibus Budget Reconciliation Act of 1989, there shall be substituted for the weighted average prevailing charge the amount provided under such section.”.

(h) **EXTENSION OF SPLIT BILLING RULE FOR INTERVENTIONAL RADIOLOGISTS.**—Section 6105(c) of the Omnibus Budget Reconciliation Act of 1989 is amended by inserting “or 1991” after “1990” each place it appears.

(i) **EFFECTIVE DATES.**—

(1) Except as otherwise provided, the amendments made by this section shall apply to services furnished on or after January 1, 1991.

(2) The amendment made by subsection (f) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

SEC. 4103. ANESTHESIA SERVICES.

(a) **REDUCTION IN FEE SCHEDULE.**—Section 1842(q)(1) (42 U.S.C. 1395u(q)(1)) is amended—

(1) by inserting “(A)” after “(q)(1)”, and

(2) by adding at the end the following new subparagraph:

“(B) For physician anesthesia services furnished under this part during 1991, the prevailing charge conversion factor used in a locality under this subsection shall be determined as follows:

“(i) The Secretary shall estimate the national weighted average of the prevailing charge conversion factors used under this subsection for services furnished during 1990 after March 31, using the best available data.

“(ii) The national weighted average estimated under clause (i) shall be reduced by 7 percent.

“(iii) Subject to clause (iv), the prevailing charge conversion factor to be applied in a locality is the sum of—

“(I) the product of (a) the portion of the reduced national weighted average prevailing charge conversion factor computed under clause (ii) which is attributable to physician work and (b) the geographic work index value for the locality (specified in Addendum C to the Model Fee Schedule for Physician Services (published on September 4, 1990, 55 Federal Register pp. 36238-36243)); and

“(II) the product of (a) the remaining portion of the reduced national weighted average prevailing charge conver-

sion factor computed under clause (ii) and (b) the geographic practice cost index value specified in section 1842(b)(14)(C)(iv) for the locality.

In applying this clause, 70 percent of the prevailing charge conversion factor shall be considered to be attributable to physician work.

“(iv) The prevailing charge conversion factor to be applied to a locality under this subparagraph shall not be reduced by more than 15 percent below the prevailing charge conversion factor applied in the locality for the period during 1990 after March 31, but in no case shall the prevailing charge conversion factor be less than 60 percent of the national weighted average of the prevailing charge conversion factors (computed under clause (i)).”.

(b) **EXTENSION OF REDUCTION FOR SUPERVISION OF CONCURRENT SERVICES.**—Section 1842(b)(13) (42 U.S.C. 1395u(b)(13)) is amended by striking “1991” each place it appears and inserting “1996”.

SEC. 4104. PHYSICIAN PATHOLOGY SERVICES.

(a) **REDUCTION IN PAYMENTS FOR PHYSICIAN PATHOLOGY SERVICES.**—Subsection (f) of section 1834 (42 U.S.C. 1395m) is amended to read as follows:

“(f) **REDUCTION IN PAYMENTS FOR PHYSICIAN PATHOLOGY SERVICES DURING FISCAL YEAR 1991.**—

“(1) **IN GENERAL.**—For physician pathology services furnished under this part during 1991, the prevailing charges used in a locality under this part shall be 7 percent below the prevailing charges used in the locality under this part in 1990 after March 31.

“(2) **LIMITATION.**—The prevailing charge for the technical and professional components of an physician pathology service furnished by a physician through an independent laboratory shall not be reduced pursuant to paragraph (1) to the extent that such reduction would reduce such prevailing charge below 115 percent of the prevailing charge for the professional component of such service when furnished by a hospital-based physician in the same locality. For purposes of the preceding sentence, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians’ office.”.

(b) **CONFORMING AMENDMENTS.**—

(1) Section 1833(a)(1)(J) of such Act (42 U.S.C. 1395l(a)(1)) is amended by striking “or physician pathology services” and by striking “or section 1834(f), respectively”.

(2) Section 1848(a)(1) of such Act (42 U.S.C. 1395w-4(a)(1)) is amended by striking “or 1834(f)”.

(3) Section 4050 of the Omnibus Budget Reconciliation Act of 1987 is repealed.

(c) **ANCILLARY POLICY.**—The Secretary of Health and Human Services, in establishing ancillary policies under section 1848(c)(3) of the Social Security Act, shall consider an appropriate adjustment to reflect the technical component of furnishing physician pathology services through a laboratory that is independent of a hospital and separate from an attending or consulting physician’s office.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after January 1, 1991.

SEC. 4105. UPDATE FOR PHYSICIANS' SERVICES.

(a) **PERCENTAGE INCREASE IN MEI FOR 1991.**—

(1) **IN GENERAL.**—Section 1842(b)(4)(E) (42 U.S.C. 1395u(b)(4)(E)) is amended by adding at the end the following new clause:

“(v) For purposes of this part for items and services furnished in 1991, the percentage increase in the MEI is—

“(I) 0 percent for services (other than primary care services), and

“(II) 2 percent for primary care services (as defined in subsection (i)(4)).”.

(2) **CUSTOMARY CHARGES FOR 1991.**—Section 1842(b)(4)(B) (42 U.S.C. 1395u(b)(4)(B)) is amended by adding at the end the following new clause:

“(iv) In determining the reasonable charge under paragraph (3) for physicians' services (other than primary care services, as defined in subsection (i)(4)) furnished during 1991, the customary charges shall be the same customary charges as were recognized under this section for the 9-month period beginning April 1, 1990. In a case in which subparagraph (F) applies (relating to new physicians) so as to limit the customary charges of a physician during 1990 to a percent of prevailing charges, the previous sentence shall not prevent such limit on customary charges under such subparagraph from increasing in 1991 to a higher percent of such prevailing charges.”.

(3) **CHANGE IN PAYMENT FOR YEARS AFTER 1991.**—Section 1848 of such Act (42 U.S.C. 1395w-4) is amended in subsection (d)(3)(A)—

(A) in clause (i), by inserting “except as provided in clause (iii),” after “subparagraph (B),” and

(B) by adding at the end the following new clause:

“(iii) **ADJUSTMENT IN PERCENTAGE INCREASE.**—In applying clause (i) for services furnished in 1992 for which the appropriate update index is the index described in clause (ii)(I), the percentage increase in the appropriate update index shall be reduced by 0.4 percentage points.”.

(b) **INCREASE IN PREVAILING CHARGE FLOOR FOR PRIMARY CARE SERVICES.**—

(1) **IN GENERAL.**—Section 1842(b)(4)(A)(vi) of such Act (42 U.S.C. 1395u(b)(4)(A)(vi)) is amended by striking “50 percent” and inserting “60 percent”.

(2) **BUDGET NEUTRAL IMPLEMENTATION.**—In computing the conversion factor under section 1848(d)(1)(B) of the Social Security Act for 1992, the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B of title XVIII of such Act for physicians' services in 1991 assuming that the amendments made by this subsection did not apply.

(3) **EFFECTIVE DATE.**—The amendments made by paragraphs (1) and (2) shall apply to services furnished on or after January 1, 1991.

(c) *VOLUME PERFORMANCE STANDARD FOR FISCAL YEAR 1991.*—Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended—

(1) in paragraph (1)(C), by striking “1990” the first place it appears and inserting “1991”, and

(2) by adding at the end of paragraph (2) the following:

“(C) Notwithstanding subparagraph (A), the performance standard rate of increase for a category of physicians’ services for fiscal year 1991 shall be the sum of—

“(i) the Secretary’s estimate of the percentage by which actual expenditures for the category of physicians’ services under this part for fiscal year 1991 exceed actual expenditures for such category of services in fiscal year 1990 (determined without regard to the amendments made by the Omnibus Budget Reconciliation Act of 1990), and

“(ii) the Secretary’s estimate of the percentage increase or decrease in expenditures for the category of services in fiscal year 1991 (compared with fiscal year 1990) that will result from changes in law and regulations (including the Omnibus Budget Reconciliation Act of 1990), reduced by 2 percentage points.”

(d) Not later than 45 days after the date of the enactment of this Act, the Secretary of Health and Human Services, based on the most recent data available, shall estimate and publish in the Federal Register the performance standard rates of increase specified in section 1848(f)(2)(C) of the Social Security Act for fiscal year 1991.

SEC. 4106. NEW PHYSICIANS AND OTHER NEW HEALTH CARE PRACTITIONERS.

(a) *EXTENSION OF CUSTOMARY CHARGE LIMIT AND INCLUSION OF HEALTH CARE PRACTITIONERS.*—

(1) *IN GENERAL.*—Subparagraph (F) of section 1842(b)(4) (42 U.S.C. 1395u(b)(4)) is amended to read as follows:

“(F)(i) In the case of physicians’ services and professional services of a health care practitioner (other than primary care services and other than services furnished in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area) furnished during the physician’s or practitioner’s first through fourth years of practice (if payment for those services is made separately under this part and on other than a cost-related basis), the prevailing charge or fee schedule amount to be applied under this part shall be 80 percent for the first year of practice, 85 percent for the second year of practice, 90 percent for the third year of practice, and 95 percent for the fourth year of practice, of the prevailing charge or fee schedule amount for that service under the other provisions of this part.

“(ii) For purposes of clause (i):

“(I) The term ‘health care practitioner’ means a physician assistant, certified nurse-midwife, qualified psychologist, nurse practitioner, clinical social worker, physical therapist, occupational therapist, respiratory therapist, certified registered nurse anesthetist, or any other practitioner as may be specified by the Secretary.

"(II) The term 'first year of practice' means, with respect to a physician or practitioner, the first calendar year during the first 6 months of which the physician or practitioner furnishes professional services for which payment is made under this part, and includes any period before such year.

"(III) The terms 'second year of practice', 'third year of practice', and 'fourth year of practice' mean the second, third, and fourth calendar years, respectively, following the first year of practice."

(2) CONFORMING AMENDMENTS.—Section 6108(a)(2)(A) of the Omnibus Budget Reconciliation Act of 1989 is amended—

(A) by inserting "or 1991" after "1990" and

(B) by inserting "or 1990" after "1989".

(b) APPLICATION UNDER FEE SCHEDULE.—

(1) IN GENERAL.—Section 1848(a) (42 U.S.C. 1395w-4(a)) is amended by adding at the end the following new paragraph:

"(4) TREATMENT OF NEW PHYSICIANS.—In the case of physicians' services furnished by a physician before the end of the physician's first full calendar year of furnishing services for which payment may be made under this part, and during each of the 3 succeeding years, the fee schedule amount to be applied shall be 80 percent, 85 percent, 90 percent, and 95 percent, respectively, of the fee schedule amount applicable to physicians who are not subject to this paragraph. The preceding sentence shall not apply to primary care services or services furnished in a rural area (as defined in section 1886(d)(2)) that is designated under section 322(a)(1)(A) of the Public Health Service Act as a health manpower shortage area."

(2) CONFORMING AMENDMENTS.—Section 1842(b)(4)(F), as amended by subsection (a), is amended—

(A) in clause (i), by striking "physicians' services and",

(B) in clause (i), by striking "physician's or", and

(C) in clause (ii)(II), by striking "physician or" each place it appears.

(c) CONFORMING ADJUSTMENT IN CONVERSION FACTOR COMPUTATION.—In computing the conversion factor under section 1848(d)(1)(B) for 1992, the Secretary of Health and Human Services shall determine the estimated aggregate amount of payments under part B for physicians' services in 1991 assuming that the amendments made by this section (notwithstanding subsection (d)) applied to all services furnished during such year.

(d) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) apply to services furnished after 1990, except that—

(A) the provisions concerning the third and fourth years of practice apply only to physicians' services furnished after 1990 and 1991, respectively, and

(B) the provisions concerning the second, third, and fourth years of practice apply only to services of a health care practitioner furnished after 1991, 1992, and 1993, respectively.

(2) The amendments made by subsection (b) shall apply to services furnished after 1991.

SEC. 4107. ASSISTANTS AT SURGERY.

(a) PHYSICIANS AS ASSISTANTS-AT-SURGERY.—

(1) *IN GENERAL.*—Section 1848(i) (42 U.S.C. 1395w-4(i)) is amended by adding at the end the following:

“(2) ASSISTANTS-AT-SURGERY.—

“(A) IN GENERAL.—Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount otherwise determined under this section for the global surgical service involved.

“(B) DENIAL OF PAYMENT IN CERTAIN CASES.—If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure performed under this part which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part for services of an assistant at surgery involved in the procedure.”

(2) *APPLICATION IN 1991.*—Section 1848(i)(2) of the Social Security Act, as added by the amendment made by paragraph (1), shall apply to services furnished in 1991 in the same manner as it applies to services furnished after 1991. In applying the previous sentence, the prevailing charge shall be substituted for the fee schedule amount.

(b) *CONFORMING AMENDMENT.*—Section 1862(a)(15) of such Act (42 U.S.C. 1395y(a)(15)) is amended—

(1) by inserting “(A)” after “(15)”,

(2) by striking “; or” at the end and inserting “; or”, and

(3) by adding at the end the following new subparagraph:

“(B) which are for services of an assistant at surgery to which section 1848(i)(2)(B) applies; or”.

(c) *EFFECTIVE DATE.*—The amendment made by subsection shall apply with respect to services furnished on or after January 1, 1992.

SEC. 4108. TECHNICAL COMPONENTS OF CERTAIN DIAGNOSTIC TESTS.

(a) *IN GENERAL.*—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)), as amended by section 4101, is further amended by adding at the end the following new paragraph:

“(18) With respect to payment under this part for the technical (as distinct from professional) component of diagnostic tests (other than clinical diagnostic laboratory tests and radiology services, including portable x-ray services) which the Secretary shall designate (based on their high volume of expenditures under this part), the reasonable charge for such technical component (including the applicable portion of a global service) may not exceed the national median of such charges for all localities, as estimated by the Secretary using the best available data.”.

(b) *EFFECTIVE DATE.*—The amendment made by subsection (a) shall apply to tests and services furnished on or after January 1, 1991.

SEC. 4109. INTERPRETATION OF ELECTROCARDIOGRAMS.

(a) *IN GENERAL.*—Section 1848(b) of the Social Security Act (42 U.S.C. 1395w-4(b)) is amended by adding at the end the following new paragraph:

“(3) *TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.*—If payment is made under this part for a visit to a physician or consultation with a physician and, as part of or in conjunction with the visit or consultation there is an electrocardiogram performed or ordered to be performed, no payment may be made under this part with respect to the interpretation of the electrocardiogram and no physician may bill an individual enrolled under this part separately for such an interpretation. If a physician knowingly and willfully bills one or more individuals in violation of the previous sentence, the Secretary may apply sanctions against the physician or entity in accordance with section 1842(j)(2).”

(b) *EFFECTIVE DATE.*—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1992. In applying section 1848(d)(1)(B) of the Social Security Act (in computing the initial budget-neutral conversion factor for 1991), the Secretary shall compute such factor assuming that section 1848(b)(3) of such Act (as added by the amendment made by subsection (a)) had applied to physicians' services furnished during 1991.

SEC. 4110. RECIPROCAL BILLING ARRANGEMENTS.

(a) *IN GENERAL.*—The first sentence of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)) is amended—

(1) by striking “and” before “(C)”, and

(2) by inserting before the period at the end the following: “, and (D) payment may be made to a physician who arranges for visit services (including emergency visits and related services) to be provided to an individual by a second physician on an occasional, reciprocal basis if (i) the first physician is unavailable to provide the visit services, (ii) the individual has arranged or seeks to receive the visit services from the first physician, (iii) the claim form submitted to the carrier includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim is for such a ‘covered visit service (and related services)’, and (iv) the visit services are not provided by the second physician over a continuous period of longer than 60 days”.

(b) *EFFECTIVE DATE.*—The amendment made by subsection (a) shall apply to services furnished on or after the first day of the first month beginning more than 60 days after the date of the enactment of this Act.

SEC. 4111. STUDY OF PREPAYMENT MEDICAL REVIEW SCREENS.

(a) *IN GENERAL.*—The Secretary of Health and Human Services shall conduct a study of the effect of the release of medicare prepayment medical review screen parameters on physician billings for the services to which the parameters apply.

(b) *LIMITATIONS.*—The study shall be based upon the release of the screen parameters at a minimum of six carriers.

(c) *REPORT.*—The Secretary shall report the results of the study to the Committees on Ways and Means and Energy and Commerce of

the House of Representatives and the Committee on Finance of the Senate not later than October 1, 1992.

SEC. 4112. PRACTICING PHYSICIANS ADVISORY COUNCIL.

Title XVIII of the Social Security Act is amended by inserting after section 1867 the following new section:

"PRACTICING PHYSICIANS ADVISORY COUNCIL

"SEC. 1868. (a) The Secretary shall appoint, based upon nominations submitted by medical organizations representing physicians, a Practicing Physicians Advisory Council (in this section referred to as the 'Council') to be composed of 15 physicians, each of whom has submitted at least 250 claims for physicians' services under this title in the previous year. At least 11 of the members of the Council shall be physicians described in section 1861(r)(1) and the members of the Council shall include both participating and nonparticipating physicians and physicians practicing in rural areas and underserved urban areas.

"(b) The Council shall meet once during each calendar quarter to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes.

"(c) Members of the Council shall be entitled to receive reimbursement of expenses and per diem in lieu of subsistence in the same manner as other members of advisory councils appointed by the Secretary are provided such reimbursement and per diem under this title."

SEC. 4113. STUDY OF AGGREGATION RULE FOR CLAIMS FOR SIMILAR PHYSICIANS' SERVICES.

The Secretary of Health and Human Services shall carry out a study of the effects of permitting the aggregation of claims that involve common issues of law and fact furnished in the same carrier area to two or more individuals by two or more physicians within the same 12-month period for purposes of appeals provided for under section 1869(b)(2). Such study shall be conducted in at least four carrier areas. The Secretary shall report on the results of such study and any recommendations to the Committee on Finance of the Senate and the Committees on Energy and Commerce and Ways and Means of the House of Representatives by December 31, 1992.

SEC. 4114. UTILIZATION SCREENS FOR PHYSICIAN VISITS IN REHABILITATION HOSPITALS.

Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue guidelines to assure a uniform level of review of physician visits to patients of a rehabilitation hospital or unit patients after the medical review screen parameter established under section 4085(h) of the Omnibus Budget Reconciliation Act of 1987 has been exceeded.

SEC. 4115. STUDY OF REGIONAL VARIATIONS IN IMPACT OF MEDICARE PHYSICIAN PAYMENT REFORM.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of—

(1) factors that may explain geographic variations in Medicare reasonable charges for physicians' services that are not attributable to variations in physician practice costs (including the supply of physicians in an area and area variations in the mix of services furnished);

(2) the extent to which the geographic practice cost indices applied under the fee schedule established under section 1848 of the Social Security Act accurately reflect variations in practice costs and malpractice costs (and alternative sources of information upon which to base such indices);

(3) the impact of the transition to a national, resource-based fee schedule for physicians' services under Medicare on access to physicians' services in areas that experience a disproportionately large reduction in payments for physicians' services under the fee schedule by reason of such variations; and

(4) appropriate adjustments or modifications in the transition to, or manner of determining payments under, the fee schedule established under section 1848 of the Social Security Act, to compensate for such variations and ensure continued access to physicians' services for Medicare beneficiaries in such areas.

(b) **REPORT.**—By not later than July 1, 1992, the Secretary shall submit to Congress a report on the study conducted under subsection (a).

SEC. 4116. LIMITATION ON BENEFICIARY LIABILITY.

Section 1848(g)(2)(A) (42 U.S.C. 1395w-4(g)(2)(A)) is amended by adding at the end thereof the following:

"In the case of evaluation and management services (as specified in section 1842(b)(16)(B)(ii)), the preceding sentence shall be applied by substituting '40 percent' for '25 percent'."

SEC. 4117. STATEWIDE FEE SCHEDULE AREAS FOR PHYSICIANS' SERVICES.

(a) **IN GENERAL.**—Notwithstanding section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w-4(j)(2)), in the case of the States of Nebraska and Oklahoma, if the respective State meets the requirements specified in subsection (b) on or before April 1, 1991, the Secretary of Health and Human Services (Secretary) shall treat the State as a single fee schedule area for purposes of determining—

(1) the adjusted historical payment basis (as defined in section 1848(a)(2)(D) of such Act (42 U.S.C. 1395w-4(a)(2)(D))), and

(2) the fee schedule amount (as referred to in section 1848(a) (42 U.S.C. 1395w-4(a)) of such Act),

for physicians' services (as defined in section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3))) furnished on or after January 1, 1992.

(b) **REQUIREMENTS.**—The requirements specified in this subsection are that (on or before April 1, 1991) there are written expressions of support for treatment of the State as a single fee schedule area (on a budget-neutral basis) from—

(1) each member of the congressional delegation from the State, and

(2) organizations representing urban and rural physicians in the State.

(c) **BUDGET NEUTRALITY.**—Notwithstanding section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)), the Secretary shall provide for treatment of a State as a single fee schedule area (as described in

subsection (a)) in a manner that ensures that total payments for physicians' services (as so defined) furnished by physicians in the State during 1992 are not greater or less than total payments for such services would have been but for such treatment.

(d) **CONSTRUCTION.**—Nothing in this section shall be construed as limiting the availability (to the Secretary, the appropriate agency or organization with a contract under section 1842, or physicians in a State) of otherwise applicable administrative procedures for modifying the fee schedule area or areas in the State after implementation of subsection (a) with respect to the State.

SEC. 4118. TECHNICAL CORRECTIONS.

(a) OVERVALUED PROCEDURES.—

(1) Section 1842(b)(14) of the Social Security Act (42 U.S.C. 1395u(b)(14)) is amended—

(A) in subparagraph (B)(iii)(I), by striking “practice expense ratio for the service (specified in table #1 in the Joint Explanatory Statement referred to in subparagraph (C)(i))” and inserting “practice expense component (percent), divided by 100, specified in appendix A (pages 187 through 194) of the Report of the Medicare and Medicaid Health Budget Reconciliation Amendments of 1989, prepared by the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives, (Committee Print 101-M, 101st Congress, 1st Session) for the service”;

(B) in subparagraph (B)(iii)(II), by striking “practice expense ratio” and inserting “practice expense component (percent), divided by 100”;

(C) in subparagraph (C)(i), by striking “physicians’ services specified in Table #2 in the Joint Explanatory Statement of the Committee of Conference submitted with the Conference Report to accompany H.R. 3299 (the ‘Omnibus Budget Reconciliation Act of 1989’), 101st Congress,” and inserting “procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee, Revised September 20, 1989, prepared by the Physician Payment Review Commission”;

(D) in subparagraph (C)(iii), by striking “The ‘percent change’ specified in this clause, for a physicians’ service specified in clause (i), is the percent change specified for the service in table #2 in the Joint Explanatory Statement” and inserting “The ‘percentage change’ specified in this clause, for a physicians’ service specified in clause (i), is the percent difference (but expressed as a positive number) specified for the service in the list”; and

(E) in subparagraph (C)(iv), by striking “such value specified for the locality in table #3 in the Joint Explanatory Statement referred to in clause (i)” and inserting “the Geographic Overhead Costs Index specified for the locality in table 1 of the September 1989 Supplement to the Geographic Medicare Economic Index: Alternative Approaches (prepared by the Urban Institute and the Center for Health Economics Research)”.

(2) Section 1842(b)(4)(E)(iv)(I) of such Act (42 U.S.C. 1395u(b)(4)(E)(iv)(I)) is amended by striking "Table #2" and all that follows through "101st Congress" and inserting "the list referred to in paragraph (14)(C)(i)".

(3) The amendments made by paragraphs (1) and (2) apply to services furnished after March 1990.

(b) **MVPS AS MULTIPLICATIVE, NOT ADDITIVE.**—Section 1848(f)(2)(A) (42 U.S.C. 1395w-4(f)(2)(A)) is amended—

(1) in the matter preceding clause (i) by striking "sum" and inserting "product";

(2) in clauses (i) through (iv), by inserting "1 plus" before "the Secretary's" each place it appears,

(3) in clause (i), by inserting "(divided by 100)" after "percentage increase";

(4) in clauses (ii) and (iv), by inserting "(divided by 100)" after "decrease";

(5) in clause (iii), by inserting "(divided by 100)" after "percentage growth"; and

(6) in the matter following clause (iv), by striking "reduced" and inserting "minus 1, multiplied by 100, and reduced".

(c) **PERIODIC REVIEW OF GEOGRAPHIC ADJUSTMENT FACTORS.**—Section 1848(e)(1) of such Act is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)", and

(2) by adding at the end the following new subparagraph:

"(C) **PERIODIC REVIEW AND ADJUSTMENTS IN GEOGRAPHIC ADJUSTMENT FACTORS.**—The Secretary, not less often than every 3 years, shall review the indices established under subparagraph (A) and the geographic index values applied under this subsection for all fee schedule areas. Based on such review, the Secretary may revise such index and adjust such index values, except that, if more than 1 year has elapsed since the last previous adjustment, the adjustment to be applied in the first year of the next adjustment shall be $\frac{1}{2}$ of the adjustment that otherwise would be made."

(d) **ELIMINATION OF RESTRICTION ON INCORPORATION OF TIME IN VISIT CODES.**—Section 1848(c)(4) (42 U.S.C. 1395w-4(c)(4)) is amended by striking "only for services furnished on or after January 1, 1993".

(e) **TREATMENT OF PRICE INCREASE IN DETERMINING PERFORMANCE STANDARD RATES OF INCREASE.**—Section 1848(f)(2)(A)(iv) (42 U.S.C. 1395w-4(f)(2)(A)(iv)) is amended by inserting "including changes in law and regulations affecting the percentage increase described in clause (i)" after "law or regulations".

(f) **MISCELLANEOUS FEE SCHEDULE CORRECTIONS.**—

(1) **CHANGES IN SECTION 1848.**—Section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended—

(A) in subsection (c)(1)(B), by striking the last sentence;

(B) in subsections (c)(3)(C)(ii)(II) and (c)(3)(C)(iii)(II), by striking "by" the first place it appears in each respective subsection,

(C) in subsection (c), by redesignating the second paragraph (3), and paragraphs (4) and (5), as paragraphs (4) through (6), respectively;

(D) in subsection (c)(4), as redesignated by subparagraph (C), is amended by striking "subsection" and inserting "section";

(E) in subsection (d)(1)(A), by striking "subparagraph (C)" and inserting "paragraph (3)";

(F) in subsection (d)(1)—

(i) in subparagraph (A)—

(I) by inserting "(or factors)" after "conversion factor" each place it appears,

(II) by inserting "or updates" after "update", and

(III) by striking "subparagraph (C)" and inserting "paragraph (3)"; and

(ii) in subparagraph (C)—

(I) in clause (i), by striking "(or factors)", and

(II) in clause (ii), by inserting "the conversion factor (or factors) which will apply to physicians' services for the following year and" before "the update (or updates)", and by striking "the following" and inserting "such";

(G) in subsection (d)(2)(A), in the matter preceding clause (i), by striking "services" the first place it appears and inserting "services (as defined in subsection (f)(5)(A))";

(H) in subsection (d)(2)(A)(ii)—

(i) by striking "(as defined in subsection (f)(5)(A))" and inserting "and for the services involved", and

(ii) by striking "all such physicians" and inserting "such"; and

(I) in the last sentence of subsection (d)(2)(A), by striking "proportion of HMO enrollees" and inserting "proportion of individuals who are enrolled under this part who are HMO enrollees";

(J) in subsection (d)(2)(E)(i), by inserting "the" after "as set forth in";

(K) in subsection (d)(2)(E)(ii)(I), by inserting "payments for" after "under this part for";

(L) in subsection (d)(3)(B)—

(i) in clause (i)—

(I) by striking "update for" and inserting "update for a category of physicians' services for"; and

(II) by striking "physicians' services (as defined in subsection (f)(5)(A))" and inserting "services in such category";

(ii) in clause (ii)—

(I) by inserting "more than" after "decrease of"; and

(II) in subclause (I), by striking "more than";

(M) in paragraphs (1)(D)(i) and (2)(A)(i) of subsection (f), by striking "calendar years" and inserting "portions of calendar years";

(N) in subsection (f)(2)(A)—

(i) by striking "each performance standard rate of increase" and inserting "the performance standard rate of increase, for all physicians' services and for each category of physicians' services,"

(ii) in clause (i), by striking "physicians' services (as defined in subsection (f)(5)(A))" and inserting "all physicians' services or for the category of physicians' services, respectively,"

(iii) in clause (iii), by striking "physicians' services" and inserting "all physicians' services or of the category of physicians' services, respectively," and

(iv) in clause (iv), by striking "physicians' services (as defined in subsection (f)(5)(A))" and inserting "all physicians' services or of the category of physicians' services, respectively,"

(O) in subsection (f)(4)(A), by striking "paragraph (B)" and inserting "subparagraph (B)";

(P) in subsection (f)(4)(B), by striking "Congress specifically approves the plan" and inserting "specifically approved by law";

(Q) in subparagraphs (A) and (B) of subsection (g)(2), by inserting "other than radiologist services subject to section 1834(b)," after "during 1991," and after "during 1992," respectively;

(R) in subsection (i)(1)(A), by striking "historical payment basis (as defined in subsection (a)(2)(C)(i))" and inserting "adjusted historical payment basis (as defined in subsection (a)(2)(D)(i))"; and

(S) in subsection (j)(1), by striking ", and such other" and all that follows through the period and inserting "(as defined by the Secretary) and all other physicians' services."

(2) MISCELLANEOUS.—

(A) Effective as if included in the Omnibus Budget Reconciliation Act of 1989, section 6102(e)(4) of such Act is amended by inserting "determined" after "prevailing charge rate".

(B) Effective January 1, 1991, section 1842(b)(3)(G) of the Social Security Act, as amended by section 6102(e)(2) of Omnibus Budget Reconciliation Act of 1989, is amended by striking "subsection (j)(1)(C)" and inserting "section 1848(g)(2)".

(C) Section 1842(b)(12)(A)(ii)(II) of the Social Security Act, as amended by section 6102(e)(4) of the Omnibus Budget Reconciliation Act of 1989, is amended by striking ", as the case may be".

(D) Section 1833(a)(1)(H) of the Social Security Act, as amended by section 6102(e)(5) of the Omnibus Budget Reconciliation Act of 1989, is amended by striking ", as the case may be".

(E) Section 6102(e)(11) of the Omnibus Budget Reconciliation Act of 1989 is amended by inserting "of Health and Human Services" after "Secretary".

(F) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, section 922(d)(1) of the Public Health Service Act (42 U.S.C. 299c-1(d)(1)) is amended—

(i) by inserting "(other than of dissemination activities)" after "evaluations", and

(ii) by inserting "research, demonstration projects, or evaluations of" after "applications with respect to".

(g) **REPEAL OF REPORTS NO LONGER REQUIRED.**—

(1) Subsection (b) of section 4043 of the Omnibus Budget Reconciliation Act of 1987 is repealed.

(2) Subsection (c) of section 4048 of such Act is repealed.

(3) Section 4049(b)(1) of such Act is amended by striking "and shall report" and all that follows up to the period at the end.

(4) Section 4056(a)(1) of such Act, as redesignated by section 411(f)(14) of the Medicare Catastrophic Coverage Act of 1988, is amended by striking the last sentence.

(5) Section 4056(b)(2) of such Act is amended by striking the second sentence.

(h) **ADJUSTMENT OF EFFECTIVE DATES.**—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987—

(1) section 4048(b) of such Act is amended by striking "January 1, 1989" and inserting "March 1, 1989", and

(2) section 4049(b)(2) of such Act is amended by striking "January 1, 1989" and inserting "April 1, 1989".

(i) **TRANSFER OF PROVISION INTO TITLE XVIII.**—

(1) Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

"(r) The Secretary shall establish a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under this title."

(2) Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking subsection (g).

(j) **PPRC.**—(1) Section 1845 of such Act (42 U.S.C. 1395w-1) is amended—

(A) in subsection (a)(3), by striking "include physicians" and inserting "include (but need not be limited to) physicians";

(B) by striking subsection (b)(3);

(C) in subsection (b)(2)—

(i) by striking "and" at the end of subparagraph (H),

(ii) by striking the period at the end of subparagraph (I) and inserting a semicolon,

(iii) by striking subparagraphs (A), (B), (C), and (F),

(iv) by redesignating subparagraphs (D), (E), (G), (H), and (I) as subparagraphs (A), (B), (C), (D), and (E), and

(v) by adding at the end the following new subparagraphs:

"(F) make recommendations regarding major issues in the implementation of the resource-based relative value scale established under section 1848(c);

"(G) make recommendations regarding further development of the volume performance standards established under section 1848(f), including the development of State-based programs;

"(H) consider policies to provide payment incentives to increase patient access to primary care and other physician services in large urban and rural areas, including policies regarding payments to physicians pursuant to title XIX;

"(I) review and consider the number and practice specialties of physicians in training and payments under this title for graduate medical education costs;

"(J) make recommendations regarding issues relating to utilization review and quality of care, including the effectiveness of peer review procedures and other quality assurance programs applicable to physicians and providers under this title and physician certification and licensing standards and procedures;

"(K) make recommendations regarding options to help constrain the costs of health insurance to employers, including incentives under this title;

"(L) comment on the recommendations affecting physician payment under the medicare program that are included in the budget submitted by the President pursuant to section 1105 of title 31, United States Code; and

"(M) make recommendations regarding medical malpractice liability reform and physician certification and licensing standards and procedures."; and

(D) by striking subsection (e) and redesignating subsection (f) as subsection (e).

(2) In Section 1842(b)(2)(A) is amended by striking "section 1845(f)(2)" and inserting "section 1845(e)(2)".

(k) PROHIBITION OF CERTAIN ADJUSTMENTS.—Section 1848(i) is amended by adding at the end the following new paragraph:

"(3) NO COMPARABILITY ADJUSTMENT.—For physicians' services for which payment under this part is determined under this section—

"(A) a carrier may not make any adjustment in the payment amount under section 1842(b)(3)(B) on the basis that the payment amount is higher than the charge applicable, for a comparable services and under comparable circumstances, to the policyholders and subscribers of the carrier,

"(B) no payment adjustment may be made under section 1842(b)(8), and

"(C) section 1842(b)(9) shall not apply .".

Subpart B—Provisions Relating to Other Items and Services

SEC. 4151. PAYMENTS FOR OUTPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—

(1) IN GENERAL.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by inserting before the period at

the end the following: “, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1992, 1993, 1994, or 1995”.

(2) **EXEMPTION FOR RURAL PRIMARY CARE HOSPITALS.**—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking “1886(d)(5)(D)(iii).” and inserting “1886(d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).”

(b) REDUCTION IN REASONABLE COSTS OF HOSPITAL OUTPATIENT SERVICES.—

(1) **IN GENERAL.**—Section 1861(v)(1)(S)(ii) (42 U.S.C. 1395x(v)(1)(S)(ii)) is amended—

(A) in subclause (II)—

(i) by striking “Subclause (I)” and inserting “Subclauses (I) and (II)”, and

(ii) by striking “capital-related costs of any hospital” and inserting “costs of hospital outpatient services provided by any hospital”;

(B) in subclause (III)—

(i) by striking “subclause (I)” and inserting “subclauses (I) and (II)”, and

(ii) by striking “capital-related” and inserting “the”;

(C) by redesignating subclauses (II) and (III) as subclauses (III) and (IV); and

(D) by inserting after subclause (I) the following new subclause:

“(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991, 1992, 1993, 1994, or 1995.”.

(2) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES.—

(A) **DEVELOPMENT OF PROPOSAL.**—The Secretary of Health and Human Services shall develop a proposal to replace the current system under which payment is made for hospital outpatient services under title XVIII of the Social Security Act with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph, the Secretary shall consider—

(i) the need to provide for appropriate limits on increases in expenditures under the medicare program;

(ii) the need to adjust prospectively determined rates to account for changes in a hospital's outpatient case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(iii) providing hospitals with incentives to control the costs of providing outpatient services;

(iv) the feasibility and appropriateness of including payment for outpatient services not currently paid on a

cost-related basis under the medicare program (including clinical diagnostic laboratory tests and dialysis services) in the system;

(v) the need to increase payments under the system to hospitals that treat a disproportionate share of low-income patients, teaching hospitals, and hospitals located in geographic areas with high wages and wage-related costs;

(vi) the feasibility and appropriateness of bundling services into larger units, such as episodes or visits, in establishing the basic unit for making payments under the system; and

(vii) the feasibility and appropriateness of varying payments under the system on the basis of whether services are provided in a free-standing or hospital-based facility.

(B) **REPORTS.**—(i) By not later than January 1, 1991, the Administrator of the Health Care Financing Administration shall submit research findings relating to prospective payments for hospital outpatient services to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives.

(ii) By not later than September 1, 1991, the Secretary shall submit the proposal developed under subparagraph (A) to such Committees.

(iii) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under subparagraph (A) to such Committees.

(C) PAYMENTS FOR AMBULATORY SURGICAL PROCEDURES AND RADIOLOGY SERVICES.—

(1) MODIFICATION OF COST AND ASC PROPORTIONS OF ASC BLEND AMOUNTS.—

(A) **IN GENERAL.**—Section 1833(i)(3)(B)(ii) (42 U.S.C. 1395l(i)(3)(B)(ii)) is amended—

(i) in subclause (I), by striking “and 50 percent for other cost reporting periods.” and inserting “50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 42 percent for portions of cost reporting periods beginning on or after January 1, 1991.”; and

(ii) in subclause (II), by striking “and 50 percent for other cost reporting periods.” and inserting “50 percent for reporting periods beginning on or after October 1, 1988, and on or before December 31, 1990, and 58 percent for portions of cost reporting periods beginning on or after January 1, 1991.”.

(B) **EXTENSION OF ASC BLEND AMOUNTS FOR EYE AND EAR AND SPECIALTY HOSPITALS.**—The last sentence of section 1833(i)(3)(B)(ii) (42 U.S.C. 1395l(i)(3)(B)(ii)) is amended by striking “in fiscal year 1989 or fiscal year 1990” and inserting “on or after October 1, 1988, and before January 1, 1995”.

(2) **MODIFICATION OF COST AND CHARGE PROPORTIONS FOR RADIOLOGY SERVICES.**—Section 1833(n)(1)(B)(ii)(I) (42 U.S.C. 1395l(n)(1)(B)(ii)(I)) is amended by striking the period at the end and inserting “, and such term means 42 percent in the case of outpatient radiology services for portions of cost reporting periods beginning on or after January 1, 1991.”

(3) **2-YEAR FREEZE IN ALLOWANCE FOR INTRAOCULAR LENSES.**—Notwithstanding section 1833(i)(2)(A)(iii) of the Social Security Act, the amount of payment determined under such section for the insertion of an intraocular lens during or subsequent to cataract surgery furnished to an individual in an ambulatory surgical center on or after the date of the enactment of this Act and on or before December 31, 1992, shall be equal to \$200.

SEC. 4152. DURABLE MEDICAL EQUIPMENT.

(a) PAYMENTS FOR SEAT-LIFT AND TENS.—

(1) **15 PERCENT REDUCTION IN PAYMENTS FOR TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS.**—Section 1834(a)(1)(D) of the Social Security Act (42 U.S.C. 1395m(a)(1)(D)) is amended by inserting before the period at the end the following: “, and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the Secretary shall further reduce such payment amount (as previously reduced) by 15 percent”.

(2) **SEAT-LIFTS.**—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by adding at the end the following: “With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.”

(3) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to items furnished on or after January 1, 1991.

(b) DEVELOPMENT AND APPLICATION OF NATIONAL LIMITS ON FEES.—

(1) **INEXPENSIVE AND ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT AND ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.**—Paragraphs (2) and (3) of section 1834(a) of such Act (42 U.S.C. 1395m(a)) are each amended—

(A) in subparagraph (B)(i), by striking “or” at the end;

(B) by striking clause (ii) of subparagraph (B) and inserting the following:

“(ii) in 1991 is the sum of (I) 67 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(I) for 1991, and (II) 33 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1991;

“(iii) in 1992 is the sum of (I) 33 percent of the local payment amount for the item or device computed under subparagraph (C)(i)(II) for 1992, and (II) 67 percent of the national limited payment amount for the item or device computed under subparagraph (C)(ii) for 1992; and

“(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year.”; and

(C) by adding at the end the following new subparagraph:

"(C) COMPUTATION OF LOCAL PAYMENT AMOUNT AND NATIONAL LIMITED PAYMENT AMOUNT.—For purposes of subparagraph (B)—

"(i) the local payment amount for an item or device for a year is equal to—

"(I) for 1991, the amount specified in subparagraph (B)(i) for 1990 increased by the covered item update for 1991, and

"(II) for 1992, the amount determined under this clause for the preceding year increased by the covered item update for 1992; and

"(ii) the national limited payment amount for an item or device for a year is equal to—

"(I) for 1991, the local payment amount determined under clause (i) for such item or device for that year, except that the national limited payment amount may not exceed 100 percent of the weighted average of all local payment amounts determined under such clause for such item for that year and may not be less than 85 percent of the weighted average of all local payment amounts determined under such clause for such item, and

"(II) for each subsequent year, the amount determined under this clause for the preceding year increased by the covered item update for such subsequent year."

(2) MISCELLANEOUS ITEMS AND OTHER COVERED ITEMS.—Section 1834(a)(8) (42 U.S.C. 1395m(a)(8)) is amended—

(A) in subparagraph (A)(ii)—

(i) by striking "or" at the end of subclause (I);

(ii) in subclause (II)—

(I) by striking "1991 or", and

(II) by striking "the percentage increase" and all that follows through the period and inserting "the covered item update for the year.";

(iii) by redesignating subclause (II) as subclause (III); and

(iv) by inserting after subclause (I) the following new subclause:

"(II) in 1991, equal to the local purchase price computed under this clause for the previous year, increased by the covered item update for 1991, and decreased by the percentage by which the average of the reasonable charges for claims paid for all items described in paragraph (7) is lower than the average of the purchase prices submitted for such items during the final 9 months of 1988; or";

(B) by amending subparagraph (B) to read as follows:

"(B) COMPUTATION OF NATIONAL LIMITED MONTHLY PAYMENT RATE.—With respect to the furnishing of a particular item in a year, the Secretary shall compute a national limited purchase price—

“(i) for 1991, equal to the local purchase price computed under subparagraph (A)(ii) for the item for the year, except that such national limited purchase price may not exceed 100 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local purchase prices for the item computed under such subparagraph for the year; and

“(ii) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.”;

(C) in subparagraph (C)—

(i) by striking “regional purchase price” each place it appears and inserting “national limited purchase price”;

(ii) by striking “and subject to subparagraph (D)”,

(iii) in clause (ii)—

(I) by striking “75” and inserting “67”; and

(II) by striking “25” and inserting “33”, and

(iv) in clause (iii)—

(I) in subclause (I), by striking “50” and inserting “33” and by striking “(A)(ii)(II)” and inserting “(A)(ii)(III)”; and

(II) in subclause (II), by striking “50” and inserting “67”; and

(D) by striking subparagraph (D).

(3) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9) of such Act (42 U.S.C. 1395m(a)(9)) is amended—

(A) in subparagraph (A)(ii)(II), by striking “the percentage increase” and all that follows through the period and inserting “the covered item increase for the year.”;

(B) by amending subparagraph (B) to read as follows:

“(B) COMPUTATION OF NATIONAL LIMITED MONTHLY PAYMENT RATE.—With respect to the furnishing of an item in a year, the Secretary shall compute a national limited monthly payment rate equal to—

“(i) for 1991, the local monthly payment rate computed under subparagraph (A)(ii)(II) for the item for the year, except that such national limited monthly payment rate may not exceed 100 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year, and may not be less than 85 percent of the weighted average of all local monthly payment rates computed for the item under such subparagraph for the year; and

“(ii) for each subsequent year, equal to the amount determined under this subparagraph for the preceding year increased by the covered item update for such subsequent year.”;

(C) in subparagraph (C)—

(i) by striking "regional monthly payment rate" each place it appears and inserting "national limited monthly payment rate",

(ii) in clause (ii)—

(I) by striking "75" and inserting "67"; and

(II) by striking "25" and inserting "33", and

(iii) in clause (iii)—

(I) in subclause (I), by striking "50" and inserting "33"; and

(II) in subclause (II), by striking "50" and inserting "67" and by striking "(B)(i)" and inserting "(B)(ii)"; and

(D) by striking subparagraph (D).

(4) **DEFINITION.**—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraph:

"(14) **COVERED ITEM UPDATE.**—In this subsection, the term 'covered item update' means, with respect to a year—

"(A) for 1991 and 1992, a reduction of 1 percentage point; and

"(B) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year."

(5) **CONFORMING AMENDMENT.**—Section 1834(a)(12) (42 U.S.C. 1395m(a)(12)) is amended by striking "defined for purposes of paragraphs (8)(B) and (9)(B)".

(c) **TREATMENT OF "RENTAL CAP" ITEMS.**—

(1) **LIMITATION ON MONTHLY RECOGNIZED RENTAL AMOUNTS FOR MISCELLANEOUS ITEMS.**—Section 1834(a)(7)(A)(i) (42 U.S.C. 1395m(a)(7)(A)(i)) is amended—

(A) by striking "for each such month" and inserting "for each of the first 3 months of such period"; and

(B) by striking the semicolon at the end and inserting the following: "; and for each of the remaining months of such period is 7.5 percent of such purchase price;"

(2) **OFFER OF OPTION TO PURCHASE FOR MISCELLANEOUS ITEMS; ESTABLISHMENT OF REASONABLE LIFETIME.**—Section 1834(a)(7) of such Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(A) in subparagraph (A)(i), by striking "15 months" and inserting "15 months, or, in the case of an item for which a purchase agreement has been entered into under clause (iii), a period of continuous use of longer than 13 months";

(B) in subparagraph (A)(ii)—

(i) by striking "(ii) during the succeeding 6-month period of medical need," and inserting "(iv) in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii), during the first 6-month period of medical need that follows the period of medical need during which payment is made under clause (i)," and

(ii) by striking "and" at the end;

(C) in subparagraph (A)(iii)—

(i) by striking "(iii)" and inserting "(v) in the case of an item for which a purchase agreement has not been entered into under clause (ii) or clause (iii)," and

(ii) by striking the period at the end and inserting "; and";

(D) by inserting after clause (i) of subparagraph (A) the following new clauses:

"(ii) in the case of a power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual patient the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the patient exercises such option;

"(iii) during the 10th continuous month during which payment is made for the rental of an item under clause (i), the supplier of such item shall offer the individual patient the option to enter into a purchase agreement under which, if the patient notifies the supplier not later than 1 month after the supplier makes such offer that the patient agrees to accept such offer and exercise such option—

"(I) the supplier shall transfer title to the item to the individual patient on the first day that begins after the 13th continuous month during which payment is made for the rental of the item under clause (i),

"(II) after the supplier transfers title to the item under subclause (I), maintenance and servicing payments shall be made in accordance with clause (v);";

(E) by inserting after clause (v) of subparagraph (A) (as amended by subparagraph (C)) the following new clause:

"(vi) in the case of an item for which a purchase agreement has been entered into under clause (ii) or clause (iii), maintenance and servicing payments may be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount established by the Secretary on the basis of reasonable charges in the locality for maintenance and servicing."; and

(F) by adding at the end the following new subparagraph:

"(C) REPLACEMENT OF ITEMS.—

"(i) ESTABLISHMENT OF REASONABLE USEFUL LIFE-TIME.—In accordance with clause (iii), the Secretary shall determine and establish a reasonable useful lifetime for items of durable medical equipment for which payment may be made under this paragraph or paragraph (3).

"(ii) PAYMENT FOR REPLACEMENT ITEMS.—If the reasonable lifetime of such an item, as so established, has been reached during a continuous period of medical need, or the carrier determines that the item is lost or irreparably damaged, the patient may elect to have

payment for an item serving as a replacement for such item made—

“(I) on a monthly basis for the rental of the replacement item in accordance with subparagraph (A); or

“(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(ii) or (A)(iii), in a lump-sum amount for the purchase of the item.

“(iii) **LENGTH OF REASONABLE USEFUL LIFETIME.**—The reasonable useful lifetime of an item of durable medical equipment under this subparagraph shall be equal to 5 years, except that, if the Secretary determines that, on the basis of prior experience in making payments for such an item under this title, a reasonable useful lifetime of 5 years is not appropriate with respect to a particular item, the Secretary shall establish an alternative reasonable lifetime for such item.”

(3) **APPLICATION OF REASONABLE USEFUL LIFETIME FOR ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.**—Section 1834(a)(3) (42 U.S.C. 1395m(a)(3)), as amended by subsection (b)(1), is further amended by adding at the end the following new subparagraph:

“(D) **REPLACEMENT OF ITEMS.**—If the reasonable useful lifetime of such an item, as established under paragraph (7)(C), has been reached during a continuous period of medical need, or the Secretary determines on the basis of investigation by the carrier that the item is lost or irreparably damaged, payment for an item serving as a replacement for such item shall be made on a monthly basis for the rental of the replacement item in accordance with subparagraph (A).”

(4) **TREATMENT OF POWER-DRIVEN WHEELCHAIRS AS MISCELLANEOUS ITEMS OF DURABLE MEDICAL EQUIPMENT.**—

(A) **IN GENERAL.**—Section 1834(a)(2)(A) (42 U.S.C. 1395m(a)(2)(A)) is amended—

- (i) in clause (i), by inserting “or” at the end;
- (ii) in clause (ii), by striking “or” at the end; and
- (iii) by striking clause (iii).

(B) **CRITERIA FOR TREATMENT OF WHEELCHAIR AS CUSTOMIZED ITEM.**—(i) Section 1834(a)(4) (42 U.S.C. 1395m(a)(4)) is amended by adding at the end the following: “In the case of a wheelchair furnished on or after January 1, 1992, the wheelchair shall be treated as a customized item for purposes of this paragraph if the wheelchair has been measured, fitted, or adapted in consideration of the patient’s body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for an individual patient’s use in accordance with instructions from the patient’s physician.”

(ii) The amendment made by clause (i) shall apply to items furnished on or after January 1, 1992, unless the Sec-

retary develops specific criteria before that date for the treatment of wheelchairs as customized items for purposes of section 1834(a)(4) of the Social Security Act (in which case the amendment made by such clause shall not become effective).

(d) **FREEZE IN REASONABLE CHARGES FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT DURING 1991.**—In determining the amount of payment under part B of title XVIII of the Social Security Act for enteral and parenteral nutrients, supplies, and equipment furnished during 1991, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such items for 1990.

(e) **REQUIRING PRIOR APPROVAL FOR POTENTIALLY OVERUSED ITEMS.**—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by subsection (b), is amended by adding at the end the following new paragraph:

“(15) **CARRIER DETERMINATIONS OF POTENTIALLY OVERUSED ITEMS IN ADVANCE.**—

“(A) **DEVELOPMENT OF LIST OF ITEMS BY SECRETARY.**—The Secretary shall develop and periodically update a list of items for which payment may be made under this subsection that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization, and shall include in such list seat-lift mechanisms, transcutaneous electrical nerve stimulators, and motorized scooters.

“(B) **DETERMINATIONS OF COVERAGE IN ADVANCE.**—A carrier shall determine in advance whether payment for an item included on the list developed by the Secretary under subparagraph (A) may not be made because of the application of section 1862(a)(1).”.

(f) **PROHIBITION AGAINST DISTRIBUTION OF MEDICAL NECESSITY FORMS BY SUPPLIERS.**—

(1) **IN GENERAL.**—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by subsections (e) and (f), is further amended by adding at the end the following new paragraph:

“(16) **PROHIBITION AGAINST DISTRIBUTION BY SUPPLIERS OF FORMS DOCUMENTING MEDICAL NECESSITY.**—

“(A) **IN GENERAL.**—A supplier of a covered item under this subsection may not distribute to physicians or to individuals entitled to benefits under this part for commercial purposes any completed or partially completed forms or other documents required by the Secretary to be submitted to show that a covered item is reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

“(B) **PENALTY.**—Any supplier of a covered item who knowingly and willfully distributes a form or other document in violation of subparagraph (A) is subject to a civil money penalty in an amount not to exceed \$1,000 for each such form or document so distributed. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in

the same manner as they apply to a penalty or proceeding under section 1128A(a).".

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to forms and documents distributed on or after January 1, 1991.

(g) **RECERTIFICATION FOR CERTAIN PATIENTS RECEIVING HOME OXYGEN THERAPY SERVICES.**—

(1) **IN GENERAL.**—Section 1834(a)(5) (42 U.S.C. 1395m(a)(5)) is amended—

(A) in subparagraph (A), by striking "(B) and (C)" and inserting "(B), (C), and (E)"; and

(B) by adding at the end the following new subparagraph:

"(E) **RECERTIFICATION FOR PATIENTS RECEIVING HOME OXYGEN THERAPY.**—In the case of a patient receiving home oxygen therapy services who, at the time such services are initiated, has an initial arterial blood gas value at or above a partial pressure of 55 or an arterial oxygen saturation at or above 89 percent (or such other values, pressures, or criteria as the Secretary may specify) no payment may be made under this part for such services after the expiration of the 90-day period that begins on the date the patient first receives such services unless the patient's attending physician certifies that, on the basis of a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 30 days of such 90-day period, there is a medical need for the patient to continue to receive such services."

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to patients who first receive home oxygen therapy services on or after January 1, 1991.

(h) **TECHNICAL CORRECTIONS.**—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section 4062(e) of such Act is amended—

(1) by inserting "(other than oxygen and oxygen equipment)" after "covered items", and

(2) by inserting before the period at the end the following: "and to oxygen and oxygen equipment furnished on or after June 1, 1989".

(i) **EFFECTIVE DATE.**—Except as otherwise provided, the amendments made by this section shall apply to items furnished on or after January 1, 1991.

SEC. 4153. PROVISIONS RELATING TO ORTHOTICS AND PROSTHETICS.

(a) **PAYMENTS FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.**—

(1) **MAINTAINING CURRENT PAYMENT METHODOLOGY.**—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(h) **PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.**—

"(1) **GENERAL RULE FOR PAYMENT.**—

"(A) **IN GENERAL.**—Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be

made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B).

“(B) **PAYMENT BASIS.**—Except as provided in subparagraph (C), the payment basis described in this subparagraph is the lesser of—

“(i) the actual charge for the item; or

“(ii) the amount recognized under paragraph (2) as the purchase price for the item.

“(C) **EXCEPTION FOR CERTAIN PUBLIC HOME HEALTH AGENCIES.**—Subparagraph (B)(i) shall not apply to an item furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

“(D) **EXCLUSIVE PAYMENT RULE.**—This subsection shall constitute the exclusive provision of this title for payment for prosthetic devices, orthotics, and prosthetics under this part or under part A to a home health agency.

“(2) **PURCHASE PRICE RECOGNIZED.**—For purposes of paragraph (1), the amount that is recognized under this paragraph as the purchase price for prosthetic devices, orthotics, and prosthetics is the amount described in subparagraph (C) of this paragraph, determined as follows:

“(A) **COMPUTATION OF LOCAL PURCHASE PRICE.**—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

“(i) The carrier shall compute a base local purchase price for each item equal to the average reasonable charge in the locality for the purchase of the item for the 12-month period ending with June 1987.

“(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

“(I) in 1989 and 1990, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 6-month period ending with December 1987, or

“(II) in 1991, 1992 or 1993, equal to the local purchase price computed under this clause for the previous year increased by the applicable percentage increase for the year.

“(B) **COMPUTATION OF REGIONAL PURCHASE PRICE.**—With respect to the furnishing of a particular item in each region (as defined by the Secretary), the Secretary shall compute a regional purchase price—

“(i) for 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

“(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for

the previous year increased by the applicable percentage increase for the year.

“(C) **PURCHASE PRICE RECOGNIZED.**—For purposes of paragraph (1) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

“(i) in 1989, 1990, or 1991, is 100 percent of the local purchase price computed under subparagraph (A)(ii);

“(ii) in 1992, is the sum of (I) 75 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1992, and (II) 25 percent of the regional purchase price computed under subparagraph (B) for 1992;

“(iii) in 1993, is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1993, and (II) 50 percent of the regional purchase price computed under subparagraph (B) for 1993; and

“(iv) in 1994 or a subsequent year, is the regional purchase price computed under subparagraph (B) for that year.

“(D) **RANGE ON AMOUNT RECOGNIZED.**—The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

“(i) in 1992, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

“(ii) in a subsequent year, may not exceed 120 percent, and may not be lower than 90 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

“(3) **APPLICABILITY OF CERTAIN PROVISIONS RELATING TO DURABLE MEDICAL EQUIPMENT.**—Paragraph (12) and subparagraphs (A) and (B) of paragraph (10) and paragraph (11) of subsection (a) shall apply to prosthetic devices, orthotics, and prosthetics in the same manner as such provisions apply to covered items under such subsection.

“(4) **DEFINITIONS.**—In this subsection—

“(A) the term ‘applicable percentage increase’ means—

“(i) for 1991, 0 percent, and

“(ii) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

“(B) the term ‘prosthetic devices’ has the meaning given such term in section 1861(s)(8), except that such term does not include parenteral and enteral nutrition nutrients, supplies, and equipment; and

“(C) the term ‘orthotics and prosthetics’ has the meaning given such term in section 1861(s)(9), but does not include intraocular lenses or medical supplies (including catheters, catheter supplies, ostomy bags, and supplies related to

ostomy care) furnished by a home health agency under section 1861(m)(5).".

(2) **CONFORMING AMENDMENTS.**—(A) Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(i) in subparagraphs (A) and (B), by striking "subparagraph (G)" each place it appears and inserting "subparagraph (G) or subparagraph (I)";

(ii) by striking "and" at the end of subparagraph (G);

(iii) by striking the period at the end of subparagraph (H) and inserting "; and"; and

(iv) by adding at the end the following new subparagraph:

"(I) prosthetic devices and orthotics and prosthetics (described in section 1834(h)(4)) furnished by a provider of services or by others under arrangements with them made by a provider of services."

(B) Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(i) by striking ", and (L)" and inserting ", (L)"; and

(ii) by striking "subparagraph and (N)" and inserting the following: "subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), and (N)".

(C) Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(i) in paragraph (2), in the matter before subparagraph (A), by striking "and (H)" and inserting "(H), and (I)";

(ii) by striking "and" at the end of paragraph (5);

(iii) by striking the period at the end of paragraph (6) and inserting "; and"; and

(iv) by adding at the end the following new paragraph:

"(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1834(h)(4)), the amounts described in section 1834(h).".

(D) Section 1834(a) (42 U.S.C. 1395m(a)), is amended—

(i) in the heading, by striking ", PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS";

(ii) in paragraph (2)(A), by striking "(13)(A)" and inserting "(13)"; and

(iii) in paragraph (13), by striking "means—" and all that follows and inserting the following: "means durable medical equipment (as defined in section 1861(n)), including such equipment described in section 1861(m)(5)).

(3) **EFFECTIVE DATE.**—The amendments made by paragraphs (1) and (2) shall apply to items furnished on or after January 1, 1991.

(b) **PROVISIONS RELATING TO EYEGLASSES.**—

(1) **PROHIBITION ON REGULATIONS.**—(A) Notwithstanding any other provision of law (except as provided in subparagraph (B)) the Secretary of Health and Human Services (referred to in this subsection as the "Secretary") may not issue any regulation that changes the coverage of conventional eyewear furnished to individuals (enrolled under part B of title XVIII of the Social Security Act) following cataract surgery with insertion of an intra-ocular lens.

(B) Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing the amendments made by paragraph (2).

(2) **CLARIFYING COVERAGE OF POST-CATARACT EYEGLASSES.**—

(A) Section 1861(s)(8) (42 U.S.C. 1395x(s)(8)) is amended by inserting after “such devices” the following “, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens”.

(B) Section 1862(a)(7) (42 U.S.C. 1395y(a)(7)) is amended by inserting after “eyeglasses” the first place it appears the following: “(other than eyewear described in section 1861(s)(8))”.

(C) The amendments made by subparagraphs (A) and (B) shall apply to items furnished on or after January 1, 1991.

(c) **GAO STUDY OF MEDICARE PAYMENTS FOR PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.**—

(1) **STUDY.**—The Comptroller General shall conduct a study of the feasibility and desirability of establishing a separate fee schedule for use in determining the amount of payments for covered items under section 1834(a) of the Social Security Act with respect to suppliers of prosthetic devices, orthotics, and prosthetics who provide professional services that would take into account the costs to such providers of providing such services.

(2) **REPORT.**—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit a report on the study conducted under subparagraph (A) to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate, and shall include in such report any recommendations regarding payments for prosthetic devices, orthotics, and prosthetics under the medicare program that the Comptroller General considers appropriate.

(d) **CLARIFICATION OF COVERAGE OF OSTOMY SUPPLIES.**—

(1) **IN GENERAL.**—Section 1866(a)(1)(P) (42 U.S.C. 1395cc(a)(1)(P)) is amended by striking “ostomy supplies” and inserting “catheters, catheter supplies, ostomy bags, and supplies related to ostomy care”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

SEC. 4154. CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) **LIMIT ON ANNUAL FEE SCHEDULE INCREASES.**—Section 1833(h)(2)(A)(ii) (42 U.S.C. 13951(h)(2)(A)(ii)) is amended—

(1) by striking “any other provision of this subsection” and inserting “clause (i)”;

(2) by striking “and” at the end of subclause (I);

(3) by striking the period at the end of subclause (II) and inserting “, and”;

(4) by adding at the end the following new subclause:

“(III) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1991, 1992, and 1993 shall be 2 percent.”.

(b) *REDUCTION IN NATIONAL CAP ON FEE SCHEDULES.*—

(1) *IN GENERAL.*—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (iii)—

(i) by inserting “and before January 1, 1991,” after “1989,” and

(ii) by striking the period at the end and inserting “, and”;

(C) by adding at the end the following new clause:

“(iv) after December 31, 1990, is equal to 88 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).”.

(2) *EFFECTIVE DATE.*—The amendments made by paragraph

(1) shall apply to tests furnished on or after January 1, 1991.

(c) *CLARIFICATION OF MANDATORY ASSIGNMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS PERFORMED BY PHYSICIANS.*—

(1) *IN GENERAL.*—(A) Section 1833(h)(5)(C) of such Act (42 U.S.C. 1395l(h)(5)(C)) is amended by striking “test performed by a laboratory other than a rural health clinic” and inserting “test, including a test performed in a physician’s office but excluding a test performed by a rural health clinic”.

(B) Section 1833(h)(5)(D) of such Act (42 U.S.C. 1395l(i)(5)(D)) is amended by striking “test performed by a laboratory, other than a rural health clinic” and inserting “test, including a test performed in a physician’s office but excluding a test performed by a rural health clinic,”.

(2) *EFFECTIVE DATE.*—The amendment made by paragraph (1)(A) shall take effect as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985, and the amendment made by paragraph (1)(B) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(d) *AGREEMENTS WITH STATES TO DETERMINE COMPLIANCE OF CLINICAL LABORATORIES WITH PROGRAM REQUIREMENTS.*—

(1) *IN GENERAL.*—Section 1864(a) (42 U.S.C. 1395aa(a)) is amended in the first sentence by striking “1861(s),” and inserting “1861(s) or (in the case of a laboratory that does not participate or seek to participate in the medicare program) the requirements of section 353 of the Public Health Service Act,”.

(2) *EFFECTIVE DATE.*—The amendment made by paragraph (1) shall take effect as if included in the enactment of the Clinical Laboratory Improvement Amendments of 1988.

(e) *TECHNICAL CORRECTIONS.*—

(1) Section 1833(h)(5)(A)(ii) of such Act (42 U.S.C. 1395l(h)(5)(A)(ii)) is amended—

(A) in subclause (II), by striking “a wholly-owned subsidiary of” and inserting “wholly owned by”;

(B) in subclause (III), by striking “laboratory” and inserting “laboratory (but not including a laboratory described in subclause (II)),”; and

(C) in subclause (III), by striking “submits bills or requests for payment in any year” and inserting “receives re-

quests for testing during the year in which the test is performed”.

(2) The heading of section 1846 of such Act is amended by striking “OF” and inserting “OR SUPPLIERS OF”.

(3) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986, section 9339(b) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking paragraph (3).

(4) Section 6111(b)(2) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking “January 1, 1990” and inserting “May 1, 1990”.

(5) The amendments made by paragraphs (1)(A) (1)(B), (2), and (4) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, and the amendment made by paragraph (1)(C) shall take effect January 1, 1991.

SEC. 4155. COVERAGE OF NURSE PRACTITIONERS IN RURAL AREAS.

(a) *IN GENERAL.*—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) in clause (ii), by striking “and” at the end;

(2) by redesignating clause (iii) as clause (iv); and

(3) by inserting after clause (ii) the following new clause:

“(iii) services which would be physicians’ services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(3)) working in collaboration (as defined in subsection (aa)(4)) with a physician (as defined in subsection (r)(1)) in a rural area (as defined in section 1886(d)(2)(D)) which the nurse practitioner or clinical nurse specialist is authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician’s professional service, and”.

(b) *PAYMENT.*—

(1) *DIRECT PAYMENT.*—Section 1832(a)(2)(B) (42 U.S.C. 1395k(a)(2)(B)) is amended—

(A) in clause (ii), by striking “and” at the end;

(B) in clause (iii), by striking the semicolon and inserting a comma; and

(C) by adding at the end the following new clause:

“(iv) services of a nurse practitioner or clinical nurse specialist provided in a rural area (as defined in section 1886(d)(2)(D)); and”.

(2) *AMOUNT.*—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking “and” at the end of subparagraph (K); and

(B) by inserting after subparagraph (L) the following new subparagraph: “(M) with respect to services described in section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), the amounts paid shall be 80 percent of the lesser of the actual charge or the prevailing charge that would be recognized

(or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by a physician (subject to the limitation described in subsection (r)(2)), and”.

(3) **CAP ON PREVAILING CHARGE; BILLING ONLY ON ASSIGNMENT-RELATED BASIS.**—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

“(r)(1) With respect to services described in section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, rural primary care hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), physician, group practice, ambulatory surgical center, with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, ambulatory surgical center.

“(2)(A) For purposes of subsection (a)(1)(M), the prevailing charge for services described in section 1861(s)(2)(K)(iii) may not exceed the applicable percentage (as defined in subparagraph (B)) of the prevailing charge (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) determined for such services performed by physicians who are not specialists.

“(B) In subparagraph (A), the term ‘applicable percentage’ means—

“(i) 75 percent in the case of services performed in a hospital, and

“(ii) 85 percent in the case of other services.

“(3)(A) Payment under this part for services described in section 1861(s)(2)(K)(iii) may be made only on an assignment-related basis, and any such assignment agreed to by a nurse practitioner or clinical nurse specialist shall be binding upon any other person presenting a claim or request for payment for such services.

“(B) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in section 1861(s)(2)(K)(iii) in violation of subparagraph (A) is subject to a civil money penalty of not to exceed \$2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(4) No hospital or rural primary care hospital that presents a claim or request for payment under this part for services described in section 1861(s)(2)(K)(iii) may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.”.

(c) **CONFORMING AMENDMENT.**—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking “section 1861(s)(2)(K)” each place it appears in paragraphs (6) and (12) and inserting “clauses (i), (ii), or (iv) of section 1861(s)(2)(K)”.

(d) **DEFINITION.**—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended by striking “The term” and all that follows through “who performs” and inserting the following: “The term ‘physician assistant’, the term ‘nurse practitioner’, and the term ‘clinical nurse specialist’ mean, for purposes of this Act, a physician assistant, nurse practitioner, or clinical nurse specialist who performs”.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after January 1, 1991.

SEC. 4156. COVERAGE OF INJECTABLE DRUGS FOR TREATMENT OF OSTEOPOROSIS.

(a) **IN GENERAL.**—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking “and” at the end of subparagraph (M),

(B) by inserting “and” at the end of subparagraph (N),
and

(C) by inserting after subparagraph (N) the following new subparagraph:

“(O) a covered osteoporosis drug and its administration (as defined in subsection (jj)) furnished on or after January 1, 1991, and on or before December 31, 1995; and”;

(2) by inserting after subsection (ii) the following new subsection:

“Covered Osteoporosis Drug

“(jj) The term ‘covered osteoporosis drug’ means an injectable drug approved for the treatment of a bone fracture related to postmenopausal osteoporosis provided to an individual if, in accordance with regulations promulgated by the Secretary—

“(1) the individual’s attending physician certifies that the patient is unable to learn the skills needed to self-administer such drug or is otherwise physically or mentally incapable of self-administering such drug; and

“(2) the individual is confined to the individual’s home (except when receiving items and services referred to in subsection (m)(7)).”.

(b) **STUDY OF EFFECTS OF COVERAGE.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall conduct a study analyzing the effects of coverage of osteoporosis drugs under part B of title XVIII of the Social Security Act (as amended by subsection (a)) on the health of individuals enrolled under such part and the utilization of inpatient hospital and extended care services by such individuals.

(2) **REPORT.**—By not later than October 1, 1994, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in such report such recommendations regarding expansion of coverage under the medicare program of items and services for individuals with postmenopausal osteoporosis as the Secretary considers appropriate.

SEC. 4157. SEPARATE PAYMENT UNDER PART B FOR SERVICES OF CERTAIN HEALTH PRACTITIONERS.

(a) **SERVICES OF CERTAIN HEALTH PRACTITIONERS NOT TO BE INCLUDED IN INPATIENT HOSPITAL SERVICES.**—Section 1861(b) (42 U.S.C. 1395x(b)) is amended—

(1) in paragraph (3), by striking "(including clinical psychologist (as defined by the Secretary))", and

(2) in paragraph (4), by striking everything after "intern" and inserting ", services described by subsection (s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and".

(b) **TREATMENT OF SERVICES FURNISHED IN INPATIENT SETTING.**—Section 1832(a)(2)(B)(iii) (42 U.S.C. 1395k(a)(2)(B)(iii)) is amended to read as follows:

"(iii) services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist;"

(c) **CONFORMING AMENDMENTS.**—

(1) Section 1862(a)(14) (42 U.S.C. 1395y) is amended—

(A) by striking "or are services of a certified registered nurse anesthetist", and

(B) by inserting after "this paragraph)" a comma and the following: "services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist,".

(2) The matter in section 1866(a)(1)(H) (42 U.S.C. 1395x(a)(1)(H)) preceding clause (i) is amended by inserting after "and other than" the following: "services described by section 1861(s)(2)(K)(i), certified nurse-midwife services, qualified psychologist services, and".

(d) **EFFECTIVE DATE.**—The amendments made by the preceding subsections apply to services furnished on or after January 1, 1991.

SEC. 4158. REDUCTION IN PAYMENTS UNDER PART B DURING FINAL 2 MONTHS OF 1990.

(a) **IN GENERAL.**—Notwithstanding any other provision of law (including any other provision of this Act, other than subsection (b)(4)), payments under part B of title XVIII of the Social Security Act for items and services furnished during the period beginning on November 1, 1990, and ending on December 31, 1990, shall be reduced by 2 percent, in accordance with subsection (b).

(b) **SPECIAL RULES FOR APPLICATION OF REDUCTION.**—

(1) **PAYMENT ON THE BASIS OF COST REPORTING PERIODS.**—In the case in which payment for services of a provider of services is made under part B of such title on a basis relating to the reasonable cost incurred for the services during a cost reporting period of the provider, the reduction made under subsection (a) shall be applied to payment for costs for such services incurred at any time during each cost reporting period of the provider any part of which occurs during the period described in such subsection, but only in the same proportion as the fraction of the cost reporting period that occurs during such period.

(2) **NO INCREASE IN BENEFICIARY CHARGES IN ASSIGNMENT-RELATED CASES.**—If a reduction in payment amounts is made under subsection (a) for items or services for which payment under part B of such title is made on an assignment-related basis (as defined in section 1842(i)(1) of the Social Security Act),

the person furnishing the items or services shall be considered to have accepted payment of the reasonable charge for the items or services, less any reduction in payment amount made under subsection (a), as payment in full.

(3) TREATMENT OF PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS.—Subsection (a) shall not apply to payments under risk-sharing contracts under section 1876 of the Social Security Act or under similar contracts under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972.

SEC. 4159. PAYMENTS FOR MEDICAL EDUCATION COSTS.

(a) HOSPITAL GRADUATE MEDICAL EDUCATION RECOUPMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services may not, before October 1, 1991, recoup payments from a hospital because of alleged overpayments to such hospital under part B of title XVIII of the Social Security Act due to a determination that the amount of payments made for graduate medical education programs exceeds the amount allowable under section 1886(h).

(2) CAP ON ANNUAL AMOUNT OF RECOUPMENT.—With respect to overpayments to a hospital described in paragraph (1), the Secretary may not recoup more than 25 percent of the amount of such overpayments from the hospital during a fiscal year.

(3) EFFECTIVE DATE.—Paragraphs (1) and (2) shall take effect October 1, 1990.

(b) UNIVERSITY HOSPITAL NURSING EDUCATION.—

(1) IN GENERAL.—The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part B of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis.

(2) CONDITIONS FOR REIMBURSEMENT.—The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) only if—

(A) the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;

(B) the proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to clinical training costs during the cost reporting period described in subparagraph (A);

(C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such program; and

(D) the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

(3) **PROHIBITION AGAINST RECOUPMENT OF COSTS BY SECRETARY.**—

(A) **IN GENERAL.**—The Secretary of Health and Human Services may not recoup payments from (or otherwise reduce or adjust payments under part B of title XVIII of the Social Security Act to) a hospital because of alleged overpayments to such hospital under such title due to a determination that costs which were reported by the hospital on its medicare cost reports for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990, relating to approved nursing and allied health education programs did not meet the requirements for allowable nursing and allied health education costs (as developed by the Secretary pursuant to section 1861(v) of such Act).

(B) **REFUND OF AMOUNTS RECOUPED.**—If, prior to the date of the enactment of this Act, the Secretary has recouped payments from (or otherwise reduced or adjusted payments under part B of title XVIII of the Social Security Act to) a hospital because of overpayments described in subparagraph (A), the Secretary shall refund the amount recouped, reduced, or adjusted from the hospital.

(4) **SPECIAL AUDIT TO DETERMINE COSTS.**—In determining the amount of costs incurred by, claimed by, and reimbursed to, a hospital for purposes of this subsection, the Secretary shall conduct a special audit (or use such other appropriate mechanism) to ensure the accuracy of such past claims and payments.

(5) **EFFECTIVE DATE.**—Except as provided in paragraph (3), the provisions of this subsection shall apply to cost reporting periods beginning on or after October 1, 1990.

SEC. 4160. CERTIFIED REGISTERED NURSE ANESTHETISTS.

Section 1833(l) (42 U.S.C. 1395l) is amended—

(1) in paragraph (1)—

(A) by inserting “(A)” after “(1)”; and

(B) by adding at the end the following:

“(B) In establishing the fee schedule under this paragraph the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology.

“(C) The provisions of this subsection shall not apply to certain services furnished in certain hospitals in rural areas under the provisions of section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989.”;

(2) by striking the second sentence of paragraph (2); and

(3) by striking paragraph (4) and inserting the following:

“(4)(A) Except as provided in subparagraphs (C) and (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is not medically directed—

“(i) the conversion factor shall be—

“(I) for services furnished in 1991, \$15.50,

"(II) for services furnished in 1992, \$15.75,

"(III) for services furnished in 1993, \$16.00,

"(IV) for services furnished in 1994, \$16.25,

"(V) for services furnished in 1995, \$16.50,

"(VI) for services furnished in 1996, \$16.75, and

"(VII) for services furnished in calendar years after 1996, the previous year's conversion factor increased by the update determined under section 1848(d)(3) for physician anesthesia services for that year;

"(ii) the payment areas to be used shall be the fee schedule areas used under section 1848 (or, in the case of services furnished during 1991, the localities used under section 1842(b)) for purposes of computing payments for physicians' services that are anesthesia services;

"(iii) the geographic adjustment factors to be applied to the conversion factor under clause (i) for services in a fee schedule area or locality is—

"(I) in the case of services furnished in 1991, the geographic work index value and the geographic practice cost index value specified in section 1842(q)(1)(B) for physicians' services that are anesthesia services furnished in the area or locality, and

"(II) in the case of services furnished after 1991, the geographic work index value, the geographic practice cost index value, and the geographic malpractice index value used for determining payments for physicians' services that are anesthesia services under section 1848,

with 70 percent of the conversion factor treated as attributable to work and 30 percent as attributable to overhead for services furnished in 1991 (and the portions attributable to work, practice expenses, and malpractice expenses in 1992 and thereafter being the same as is applied under section 1848).

"(B)(i) Except as provided in clause (ii) and subparagraph (D), in determining the amount paid under the fee schedule under this subsection for services furnished on or after January 1, 1991, by a certified registered nurse anesthetist who is medically directed, the Secretary shall apply the same methodology specified in subparagraph (A).

"(ii) The conversion factor used under clause (i) shall be—

"(I) for services furnished in 1991, \$10.50,

"(II) for services furnished in 1992, \$10.75,

"(III) for services furnished in 1993, \$11.00,

"(IV) for services furnished in 1994, \$11.25,

"(V) for services furnished in 1995, \$11.50,

"(VI) for services furnished in 1996, \$11.70, and

"(VII) for services furnished in calendar years after 1997, the previous year's conversion factor increased by the update determined under section 1848(d)(3) for physician anesthesia services for that year.

"(C) Notwithstanding subclauses (I) through (V) of subparagraph (A)(i)—

"(i) in the case of a 1990 conversion factor that is greater than \$16.50, the conversion factor for a calendar year after 1990 and before 1996 shall be the 1990 conversion factor reduced by

the product of the last digit of the calendar year and one-fifth of the amount by which the 1990 conversion factor exceeds \$16.50; and

"(ii) in the case of a 1990 conversion factor that is greater than \$15.49 but less than \$16.51, the conversion factor for a calendar year after 1990 and before 1996 shall be the greater of—

"(I) the 1990 conversion factor, or

"(II) the conversion factor specified in subparagraph (A)(i) for the year involved.

"(D) Notwithstanding subparagraph (C), in no case may the conversion factor used to determine payment for services in a fee schedule area or locality under this subsection, as adjusted by the adjustment factors specified in subparagraphs (A)(iii), exceed the conversion factor used to determine the amount paid for physicians' services that are anesthesia services in the area or locality."

SEC. 4161. COMMUNITY HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) COMMUNITY HEALTH CENTERS.—

(1) COVERAGE.—Section 1861(s)(2)(E) of the Social Security Act (42 U.S.C. 1395x(s)(2)(E)) is amended by inserting "and Federally qualified health center services" after "rural health clinic services".

(2) SERVICES DEFINED.—Section 1861(aa) of such Act is amended—

(A) in the heading, by adding at the end the following: "and Federally Qualified Health Center Services",

(B) in paragraph (3), by striking "paragraphs (1) and (2)" and inserting "the previous provisions of this subsection" and by redesignating such paragraph and paragraph (4) as paragraph (5) and (6), respectively, and

(C) by inserting after paragraph (2) the following new paragraphs:

"(3) The term 'Federally qualified health center services' means—

"(A) services of the type described in subparagraphs (A) through (C) of paragraph (1), and

"(B) preventive primary health services that a center is required to provide under sections 329, 330, and 340 of the Public Health Service Act,

when furnished to an individual as an outpatient of a Federally qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively.

"(4) The term 'Federally qualified health center' means an entity which—

"(A)(i) is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or

"(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 329, 330, or 340 of such Act;

"(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service,

is determined by the Secretary to meet the requirements for receiving such a grant; or

"(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990."

(3) **PAYMENTS.**—

(A) **IN GENERAL.**—Section 1832(a)(2)(D) of such Act (42 U.S.C. 1395k(a)(2)(D)) is amended by inserting "(i)" after "(D)" and by inserting "and (ii) Federally qualified health center services" after "rural health clinic services".

(B) **DEDUCTIBLE DOES NOT APPLY.**—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended—

(i) by striking "and" before "(4)",

(ii) by inserting before the period at the end the following: ", and (5) such deductible shall not apply to Federally qualified health center services".

(C) **EXCLUSION FROM PAYMENT REMOVED.**—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (2), by inserting ", except in the case of Federally qualified health center services" before the semicolon at the end, and

(ii) in paragraph (3), by inserting ", in the case of Federally qualified health center services, as defined in section 1861(aa)(3)," after "1861(aa)(1)," and

(iii) by adding at the end the following new sentence: "Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B)."

(4) **WAIVER OF ANTI-KICKBACK REQUIREMENT.**—Section 1128B(b)(3) of such Act (42 U.S.C. 1320a-7b(b)(3)) is amended—

(A) by striking "and" at the end of subparagraph (C),

(B) by redesignating subparagraph (D) as subparagraph (E), and

(C) by inserting after subparagraph (C) the following new subparagraph:

"(D) a waiver of any coinsurance under part B of title XVIII by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; and"

(5) **CONFORMING AMENDMENTS.**—Section 1861 of such Act (42 U.S.C. 1395x) is further amended—

(A) in subsections (s)(2)(H)(i) and (s)(2)(K), by striking "subsection (aa)(3)" and "subsection (aa)(4)" each place either appears inserting "subsection (aa)(5)" and "subsection (aa)(6)", respectively, and

(B) in subsection (aa)(1)(B), by striking "paragraph (3)" and inserting "paragraph (5)".

(6) **PRRB REVIEW OF COST REPORTS FOR FEDERALLY QUALIFIED HEALTH CENTERS.**—Section 1878 of the Social Security Act (42 U.S.C. 1395oo) is amended by adding at the end the following new subsection:

"(j) In this section, the term 'provider of services' includes a Federally qualified health center."

(7) GAO STUDY OF HOSPITAL STAFF PRIVILEGES FOR PHYSICIANS PRACTICING IN COMMUNITY HEALTH CENTERS.—

(A) STUDY.—The Comptroller General shall conduct a study of whether physicians practicing in community and migrant health centers are able to obtain admitting privileges at local hospitals. The study shall review—

(i) how many physicians practicing in such centers are without hospital admitting privileges or have been denied admitting privileges at a local hospital, and

(i)(I) the criteria hospitals use in deciding whether to grant admitting privileges and (II) whether such criteria act as significant barriers to health center physicians obtaining hospital privileges.

(B) REPORT.—By not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit a report on the study under subparagraph (A) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and shall include in such report such recommendations as the Comptroller General deems appropriate.

(8) EFFECTIVE DATE.—(A) Subject to subparagraphs (B) and (C), the amendments made by this section shall apply to services furnished on or after October 1, 1991.

(B) In the case of a Federally qualified health care center that has elected, as of January 1, 1990, under part B of title XVIII of the Social Security Act, to have the amount of payments for services under such part determined on a reasonable-charge basis, the amendment made by paragraph (3)(A) shall only apply on and after such date (not earlier than October 1, 1991) as the center may elect.

(C) The amendment made by paragraph (6) shall apply to cost reports for periods beginning on or after October 1, 1991.

(b) RURAL HEALTH CLINIC SERVICES.—

(1) EXPEDITED CERTIFICATION.—Section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)) is amended by adding at the end the following: “If a State agency has determined under section 1864(a) that a facility is a rural health clinic and the facility has applied to the Secretary for certification as such a clinic, the Secretary shall notify the facility of the the Secretary’s approval or disapproval of the certification not later than 60 days after the date of the State agency determination or the application (whichever is later).”.

(2) TEMPORARY WAIVER OF STAFFING REQUIREMENTS.—Section 1861(aa) of such Act, as amended by subsection (a), is further amended by adding at the end the following new paragraph:

“(7)(A) The Secretary shall waive for a 1-year period the requirements of paragraph (2) that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife or that such clinic require such providers to furnish services at least 50 percent of the time that the clinic operates for any facility that requests such waiver if the facility demonstrates that the facility has been unable, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period.

"(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility.

"(C) A waiver which is requested under this paragraph shall be deemed granted unless such request is denied by the Secretary within 60 days after the date such request is received."

(3) **PRODUCTIVITY SCREENS.**—In employing any screening guideline in determining the productivity of physicians, physician assistants, nurse practitioners, and certified nurse-midwives in a rural health clinic, the Secretary of Health and Human Services shall provide that the guideline shall take into account the combined services of such staff (and not merely the service within each class of practitioner).

(4) **PRRB REVIEW OF COST REPORTS FOR RURAL HEALTH CENTERS.**—Section 1878(j) of the Social Security Act (42 U.S.C. 1395oo(j)), as added by subsection (a)(6), is amended by inserting "a rural health clinic and" after "includes".

(5) **EFFECTIVE DATE.**—This subsection shall take effect on October 1, 1991, except that the amendment made by paragraph (4) shall apply to cost reports for periods beginning on or after October 1, 1991.

SEC. 4162. PARTIAL HOSPITALIZATION IN COMMUNITY MENTAL HEALTH CENTERS.

(a) **IN GENERAL.**—Section 1861(ff)(3) of the Social Security Act (42 U.S.C. 1395x(ff)(3)) is amended—

(1) by striking "(3)" and inserting "(3)(A)";

(2) by striking "outpatients" and inserting "outpatients or by a community mental health center (as defined in subparagraph (B)),"; and

(3) by adding at the end the following new subparagraph:

"(B) For purposes of subparagraph (A), the term 'community mental health center' means an entity—

"(i) providing the services described in section 1916(c)(4) of the Public Health Service Act; and

"(ii) meeting applicable licensing or certification requirements for community mental health centers in the State in which it is located."

(b) **CONFORMING AMENDMENTS.**—(1) Section 1832(a)(2) of such Act (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (H);

(B) by striking the period at the end of subparagraph (I) and inserting "; and"; and

(C) by adding at the end the following new subparagraph:

"(J) partial hospitalization services provided by a community mental health center (as described in section 1861(ff)(2)(B))."

(2) Section 1866(e) of such Act (42 U.S.C. 1395cc(e)) is amended by striking "include a clinic" and all that follows through the period and inserting the following: "include—

"(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or

agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and

"(2) a community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1))."

(c) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b) shall apply with respect to partial hospitalization services provided on or after October 1, 1991.

SEC. 4163. COVERAGE OF SCREENING MAMMOGRAPHY.

(a) **IN GENERAL.**—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)—

(A) in paragraph (11), by striking all that follows "(bb))" and inserting a semicolon,

(B) in paragraph (12)(C), by striking all that follows "area)" and inserting "; and", and

(C) by inserting after paragraph (12) the following new paragraph:

"(13) screening mammography (as defined in subsection (jj));"; and

(2) by inserting after subsection (ii) the following new subsection:

"Screening Mammography

"(jj) The term 'screening mammography' means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure."

(b) **PAYMENT AND COVERAGE.**—Section 1834 of such Act (42 U.S.C. 1395m) is amended—

(1) in subsection (b)(1)(B), by inserting "and subject to subsection (c)(1)(A)" after "conversion factors", and

(2) by inserting after subsection (b) the following new subsection:

"(c) **PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.**—

"(1) **IN GENERAL.**—Notwithstanding any other provision of this part, with respect to expenses incurred for screening mammography (as defined in section 1861(jj))—

"(A) payment may be made only for screening mammography conducted consistent with the frequency permitted under paragraph (2);

"(B) payment may be made only if the screening mammography meets the quality standards established under paragraph (3); and

“(C) the amount of the payment under this part shall, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

“(i) the actual charge for the screening,

“(ii) the fee schedule established under subsection (b) or the fee schedule established under section 1848, whichever is applicable, with respect to both the professional and technical components of the screening mammography, or

“(iii) the limit established under paragraph (4) for the screening mammography.

“(2) FREQUENCY COVERED.—

“(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

“(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

“(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

“(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

“(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months following the month in which a previous screening mammography was performed, or

“(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months following the month in which a previous screening mammography was performed.

“(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

“(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months following the month in which a previous screening mammography was performed.

“(B) REVISION OF FREQUENCY.—

“(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

“(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which

screening mammography may be paid for under this subsection, but no such revision shall apply to screening mammography performed before January 1, 1992.

"(3) **QUALITY STANDARDS.**—The Secretary shall establish standards to assure the safety and accuracy of screening mammography performed under this part. Such standards shall include the requirements that—

"(A) the equipment used to perform the mammography must be specifically designed for mammography and must meet radiologic standards established by the Secretary for mammography;

"(B) the mammography must be performed by an individual who—

"(i) is licensed by a State to perform radiological procedures, or

"(ii) is certified as qualified to perform radiological procedures by such an appropriate organization as the Secretary specifies in regulations;

"(C) the results of the mammography must be interpreted by a physician—

"(i) who is certified as qualified to interpret radiological procedures by such an appropriate board as the Secretary specifies in regulations, or

"(ii) who is certified as qualified to interpret screening mammography procedures by such a program as the Secretary recognizes in regulation as assuring the qualifications of the individual with respect to such interpretation; and

"(D) with respect to the first screening mammography performed on a woman for which payment is made under this part, there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman.

"(4) **LIMIT.**—

"(A) \$55, INDEXED.—Except as provided by the Secretary under subparagraph (B), the limit established under this paragraph—

"(i) for screening mammography performed in 1991, is \$55, and

"(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year increased by the percentage increase in the MEI for that subsequent year.

"(B) **REDUCTION OF LIMIT.**—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1992, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

"(C) **APPLICATION OF LIMIT IN HOSPITAL OUTPATIENT SETTING.**—The Secretary shall provide for an appropriate allo-

cation of the limit established under this paragraph between professional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where there is a claim for professional services separate from the claim for the radiologic procedure.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of mammography screening performed on or after January 1, 1991, for which payment is made under this subsection, if a nonparticipating physician or supplier provides the screening to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B), or if less, as defined in subsection (b)(5)(B) or as defined in section 1848(g)(2)).

"(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, with respect to screening mammography performed—

"(i) in 1991, 125 percent of the limit established under paragraph (4),

"(ii) in 1992, 120 percent of the limit established under paragraph (4), or

"(iii) after 1992, 115 percent of the limit established under paragraph (4).

"(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2)."

(c) CERTIFICATION OF SCREENING MAMMOGRAPHY QUALITY STANDARDS.—

(1) Section 1863 of such Act (42 U.S.C. 1395z) is amended by inserting "or whether screening mammography meets the standards established under section 1834(c)(3)," after "1832(a)(2)(F)(i)."

(2) The first sentence of section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended by inserting before the period the following: "; or whether screening mammography meets the standards established under section 1834(c)(3)".

(3) Section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by inserting "1834(c)(3)," after "1832(a)(2)(F)(i)."

(d) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(2)(E) of such Act (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting "; but excluding screening mammography" after "imaging services".

(2) Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraph (B), (C), (D), or (E)" and inserting "a succeeding subparagraph",

(ii) in subparagraph (D), by striking "and" at the end,

(iii) in subparagraph (E), by striking the semicolon at the end and inserting "; and", and

(iv) by adding at the end the following new subparagraph:

“(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(c)(2) or which does not meet the standards established under section 1834(c)(3), and, in the case of screening pap smear, which is performed more frequently than is provided under section 1861(nn);” and

(B) in paragraph (7), by inserting “or under paragraph (1)(F)” after “(1)(B)”.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to screening mammography performed on or after January 1, 1991.

SEC. 4164. MISCELLANEOUS AND TECHNICAL PROVISIONS RELATING TO PART B.

(a) **EXTENSION OF DEMONSTRATIONS.**—

(1) **PREVENTION DEMONSTRATIONS.**—Section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 9344 of the Omnibus Budget Reconciliation Act of 1986, is amended—

(A) in subsection (a), by striking “4-year” and inserting “5-year”;

(B) in subsection (e)(2), by striking “Not later than five years after the date of the enactment of this Act, the Secretary shall submit a final report” and inserting “Not later than April 1, 1993, the Secretary shall submit an interim report”;

(C) in subsection (e), by adding at the end the following new paragraph:

“(3) Not later than April 1, 1995, the Secretary shall submit a final report to those Committees on the demonstration program and shall include in the report a comprehensive evaluation of the long-term effects of the program.”;

(D) in subsection (f), by striking “\$5,900,000” and inserting “\$7,500,000”; and

(E) in subsection (f), by inserting before the period at the end the following: “and shall not exceed \$3,000,000 for the comprehensive evaluation referred to in subsection (e)(3)”.

(2) **ALZHEIMER’S DISEASE DEMONSTRATION PROJECTS.**—Section 9342 of the Omnibus Budget Reconciliation Act of 1986 is amended—

(A) in subsection (c)(1), by striking “3 years” and inserting “4 years”;

(B) in subsection (d)(1), by striking “third year” and inserting “fourth year”;

(C) in subsection (f)—

(i) by striking “\$40,000,000” and inserting “\$55,000,000”, and

(ii) by striking “\$2,000,000” and inserting “\$3,000,000”.

(b) **DISCLOSURE OF OWNERSHIP.**—

(1) *IN GENERAL.*—Title XI of the Social Security Act is amended by inserting after section 1124 the following new section:

"DISCLOSURE REQUIREMENTS FOR OTHER PROVIDERS UNDER PART B OF MEDICARE

"SEC. 1124A. (a) DISCLOSURE REQUIRED TO RECEIVE PAYMENT.—No payment may be made under part B of title XVIII for items or services furnished by any disclosing part B provider unless such provider has provided the Secretary with full and complete information—

"(1) on the identity of each person with an ownership or control interest in the provider or in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 percent or more ownership interest; and

"(2) with respect to any person identified under paragraph (1) or any managing employee of the provider—

"(A) on the identity of any other entities providing items or services for which payment may be made under title XVIII of the Social Security Act with respect to which such person or managing employee is a person with an ownership or control interest at the time such information is supplied or at any time during the 3-year period ending on the date such information is supplied, and

"(B) as to whether any penalties, assessments, or exclusions have been assessed against such person or managing employee under section 1128, 1128A, or 1128B.

"(b) UPDATES TO INFORMATION SUPPLIED.—A disclosing part B provider shall notify the Secretary of any changes or updates to the information supplied under subsection (a) not later than 180 days after such changes or updates take effect.

"(c) DEFINITIONS.—For purposes of this section—

"(1) the term 'disclosing part B provider' means any entity receiving payment on an assignment-related basis for furnishing items or services for which payment may be made under part B of title XVIII, except that such term does not include an entity described in section 1124(a)(2);

"(2) the term 'managing employee' means, with respect to a provider, a person described in section 1126(b); and

"(3) the term 'person with an ownership or control interest' means, with respect to a provider—

"(A) a person described in section 1124(a)(3), or

"(B) a person who has one of the 5 largest direct or indirect ownership or control interests in the provider."

(2) CRIMINAL PENALTY FOR PROVIDING FALSE INFORMATION.—Section 1128B(c) of such Act (42 U.S.C. 1320a-7b(c)) is amended by striking "health care program" and inserting "health care program, or with respect to information required to be provided under section 1124A,".

(3) FAILURE TO PROVIDE INFORMATION AS GROUNDS FOR PERMISSIVE EXCLUSION FROM PROGRAM.—Section 1128(b)(9) of such Act (42 U.S.C. 1320a-7(b)(9)) is amended by striking "1124" and inserting "1124, section 1124A,".

(4) **EFFECTIVE DATE.**—The amendments made by paragraph (1), (2), and (3) shall apply with respect to items or services furnished on or after—

(A) January 1, 1993, in the case of items or services furnished by a provider who, on or before the date of the enactment of this Act, has furnished items or services for which payment may be made under part B of title XVIII of the Social Security Act; or

(B) January 1, 1992, in the case of items or services furnished by any other provider.

(c) **DIRECTORY OF UNIQUE PHYSICIAN IDENTIFIER NUMBERS.**—Not later than March 31, 1991, the Secretary of Health and Human Services shall publish a directory of the unique physician identification numbers of all physicians providing services for which payment may be made under part B of title XVIII of the Social Security Act, and shall include in such directory the names, provider numbers, and billing addressess of all listed physicians.

PART 3—PROVISIONS RELATING TO PARTS A AND B

SEC. 4201. PROVISIONS RELATING TO END STAGE RENAL DISEASE.

(a) **INCREASE IN COMPOSITE RATES.**—Section 9335(a)(1) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6203(a)(1) of the Omnibus Budget Reconciliation Act of 1989, is amended—

(1) by striking “October 1, 1990,” and inserting “December 31, 1990,”; and

(2) by inserting after the first sentence the following: “With respect to services furnished on or after January 1, 1991, such base rate shall be equal to the respective rate in effect as of September 30, 1990 (determined without regard to any reductions imposed pursuant to section 6201 of the Omnibus Budget Reconciliation Act of 1989), increased by \$1.00.”.

(b) **PROPAC STUDY ON ESRD COMPOSITE RATES.**—

(1) **IN GENERAL.**—

(A) **STUDY.**—The Prospective Payment Assessment Commission (in this subsection referred to as the “Commission”) shall conduct a study to determine the costs and services and profits associated with various modalities of dialysis treatments provided to end stage renal disease patients provided under title XVIII of the Social Security Act.

(B) **RECOMMENDATIONS.**—Based on information collected for the study described in subparagraph (A), the Commission shall make recommendations to Congress regarding the method or methods and the levels at which the payments made for the facility component of dialysis services by providers of service and renal dialysis facilities under title XVIII of the Social Security Act should be established for dialysis services furnished during fiscal year 1993 and the methodology to be used to update such payments for subsequent fiscal years. In making recommendations con-

cerning the appropriate methodology the Commission shall consider—

- (i) hemodialysis and other modalities of treatment,
- (ii) the appropriate services to be included in such payments,
- (iii) the adjustment factors to be incorporated including facility characteristics, such as hospital versus free-standing facilities, urban versus rural, size and mix of services,
- (iv) adjustments for labor and nonlabor costs,
- (v) comparative profit margins for all types of renal dialysis providers of service and renal dialysis facilities,
- (vi) adjustments for patient complexity, such as age, diagnosis, case mix, and pediatric services, and
- (vii) efficient costs related to high quality of care and positive outcomes for all treatment modalities.

(2) **REPORT.**—Not later than June 1, 1992, the Commission shall submit a report to the Committee on Finance of the Senate, and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on the study conducted under paragraph (1)(A) and shall include in the report the recommendations described in paragraph (1)(B), taking into account the factors described in paragraph (1)(B).

(3) **ANNUAL REPORT.**—The Commission, not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1993) shall report its recommendations to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on an appropriate change factor which should be used for updating payments for services rendered in that fiscal year. The Commission in making such report to Congress shall consider conclusions and recommendations available from the Institute of Medicine.

(c) **PAYMENT RATES FOR ERYTHROPOIETIN.**—

(1) **IN GENERAL.**—Section 1881(b)(11) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended—

(A) by striking “(11)” and inserting “(11)(A)”; and

(B) by adding at the end the following new subparagraph:

“(B) Erythropoietin, when provided to a patient determined to have end stage renal disease, shall not be included as a dialysis service for purposes of payment under any prospective payment amount or comprehensive fee established under this section, and payment for such item shall be made separately—

“(i) in the case of erythropoietin provided by a physician, in accordance with section 1833; and

“(ii) in the case of erythropoietin provided by a provider of services, renal dialysis facility, or other supplier of home dialysis supplies and equipment—

“(I) for erythropoietin provided during 1991, in an amount equal to \$11 per thousand units (rounded to the nearest 100 units), and

"(II) for erythropoietin provided during a subsequent year, in an amount determined to be appropriate by the Secretary, except that such amount may not exceed the amount determined under this clause for the previous year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce) for the second quarter of the preceding year over the implicit price deflator for the second quarter of the second preceding year."

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to erythropoietin furnished on or after January 1, 1991.

(d) **SELF-ADMINISTERED ERYTHROPOIETIN.**—

(1) **COVERAGE.**—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), is amended—

(A) by striking "and" at the end of subparagraph (O);

(B) by adding "and" at the end of subparagraph (P); and

(C) by adding at the end the following new subparagraph:

"(Q) erythropoietin for home dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;"

(2) **COVERAGE FOR METHOD II PATIENTS.**—Section 1881(b) (42 U.S.C. 1395rr(b)) is further amended—

(A) in paragraph (1)—

(B) by striking "and (B)" and inserting "(B), and

(C) by striking "equipment." and inserting "equipment, and (C) payments to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for self-administered erythropoietin as described in section 1861(s)(2)(Q) if the Secretary finds that the patient receiving such drug from such a supplier can safely and effectively administer the drug (in accordance with the applicable methods and standards established by the Secretary pursuant to such section)."; and

(3) by adding at the end of paragraph (11), as amended by subsection (c), the following new subparagraph:

"(C) The amount payable to a supplier of home dialysis supplies and equipment that is not a provider of services, a renal dialysis facility, or a physician for erythropoietin shall be determined in the same manner as the amount payable to a renal dialysis facility for such item."

(3) **EFFECTIVE DATE.**—The amendments made by paragraphs (1) and (2) shall apply to items and services furnished on or after July 1, 1991.

SEC. 4202. STAFF-ASSISTED HOME DIALYSIS DEMONSTRATION PROJECT.

(a) **ESTABLISHMENT.**—

(1) **IN GENERAL.**—Not later than 9 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish and carry out a 3-year demonstration project to determine whether the services of a home dialysis

staff assistant providing services to a patient during hemodialysis treatment at the patient's home may be covered under the medicare program in a cost-effective manner that ensures patient safety.

(2) **NUMBER OF PARTICIPANTS.**—The total number of eligible patients receiving services under the demonstration project established under paragraph (1) may not exceed 800.

(b) **PAYMENTS TO PARTICIPATING PROVIDERS AND FACILITIES.**—

(1) **SERVICES FOR WHICH PAYMENT MAY BE MADE.**—

(A) **IN GENERAL.**—Under the demonstration project established under subsection (a), the Secretary shall make payments for 3 years under title XVIII of the Social Security Act to providers of services (other than a skilled nursing facility) or renal dialysis facilities for services of a home hemodialysis staff assistant provided to an individual described in subsection (c) during hemodialysis treatment at the individual's home in an amount determined under paragraph (2).

(B) **SERVICES DESCRIBED.**—For purposes of subparagraph (A), the term "services of a home hemodialysis staff assistant" means—

(i) technical assistance with the operation of a hemodialysis machine in the patient's home and with such patient's care during in-home hemodialysis; and

(ii) administration of medications within the patient's home to maintain the patency of the extra corporeal circuit.

(2) **AMOUNT OF PAYMENT.**—

(A) **IN GENERAL.**—Payment to a provider of services or renal dialysis facility participating in the demonstration project established under subsection (a) for the services described in paragraph (1) shall be prospectively determined by the Secretary, made on a per treatment basis, and shall be in an amount determined under subparagraph (B).

(B) **DETERMINATION OF PAYMENT AMOUNT.**—(i) The amount of payment made under subparagraph (A) shall be the product of—

(I) the rate determined under clause (ii) with respect to a provider of services or a renal dialysis facility; and

(II) the factor by which the labor portion of the composite rate determined under section 1881(b)(7) of the Social Security Act is adjusted for differences in area wage levels.

(ii) The rate determined under this clause, with respect to a provider of services or renal dialysis facility, shall be equal to the difference between—

(I) two-thirds of the labor portion of the composite rate applicable under section 1881(b)(7) of such Act to the provider or facility (as adjusted to reflect differences in area wage levels), and

(II) the product of the national median hourly wage for a home hemodialysis staff assistant and the national median time expended in the provision of home he-

modialysis staff assistant services (taking into account time expended in travel and predialysis patient care).

(iii) For purposes of clause (ii)(II)—

(I) the national median hourly wage for a home hemodialysis staff assistant and the national median average time expended for home hemodialysis staff assistant services shall be determined annually on the basis of the most recent data available, and

(II) the national median hourly wage for a home hemodialysis staff assistant shall be the sum of 65 percent of the national median hourly wage for a licensed practical nurse and 35 percent of the national median hourly wage for a registered nurse.

(C) **PAYMENT AS ADD-ON TO COMPOSITE RATE.**—The amount of payment determined under this paragraph shall be in addition to the amount of payment otherwise made to the provider of services or renal dialysis facility under section 1881(b) of such Act.

(c) **INDIVIDUALS ELIGIBLE TO RECEIVE SERVICES UNDER PROJECT.**—

(1) **IN GENERAL.**—An individual may receive services from a provider of services or renal dialysis facility participating in the demonstration project if—

(A) the individual is not a resident of a skilled nursing facility;

(B) the individual is an end stage renal disease patient entitled to benefits under title XVIII of the Social Security Act;

(C) the individual's physician certifies that the individual is confined to a bed or wheelchair and cannot transfer themselves from a bed to a chair;

(D) the individual has a serious medical condition (as specified by the Secretary) which would be exacerbated by travel to and from a dialysis facility;

(E) the individual is eligible for ambulance transportation to receive routine maintenance dialysis treatments, and, based on the individual's medical condition, there is reasonable expectation that such transportation will be used by the individual for a period of at least 6 consecutive months, such that the cost of ambulance transportation can reasonably be expected to meet or exceed the cost of home hemodialysis staff assistance as provided under subsection (b)(4); and

(F) no family member or other individual is available to provide such assistance to the individual.

(2) **COVERAGE OF INDIVIDUALS CURRENTLY RECEIVING SERVICES.**—Any individual who, on the date of the enactment of this Act, is receiving staff assistance under the experimental authority provided under section 1881(f)(2) of the Social Security Act shall be deemed to be an eligible individual for purposes of this subsection.

(3) **CONTINUATION OF COVERAGE UPON TERMINATION OF PROJECT.**—Notwithstanding any provision of title XVIII of the Social Security Act, any individual receiving services under the

demonstration project established under subsection (a) as of the date of the termination of the project shall continue to be eligible for home hemodialysis staff assistance after such date under such title on the same terms and conditions as applied under the demonstration project.

(d) **QUALIFICATIONS FOR HOME HEMODIALYSIS STAFF ASSISTANTS.**—For purposes of subsection (b), a home dialysis aide is qualified if the aide—

(1) meets minimum qualifications as specified by the Secretary; and

(2) meets any applicable qualifications as specified under the law of the State in which the home hemodialysis staff assistant is providing services.

(e) **REPORTS.**—

(1) **INTERIM STATUS REPORT.**—Not later than December 1, 1992, the Secretary shall submit to Congress a preliminary report on the status of the demonstration project established under subsection (a).

(2) **FINAL REPORT.**—Not later than December 31, 1995, the Secretary shall submit to Congress a final report evaluating the project, and shall include in such report recommendations regarding appropriate eligibility criteria and cost-control mechanisms for medicare coverage of the services of a home dialysis aide providing medical assistance to a patient during hemodialysis treatment at the patient's home.

(f) **AUTHORIZATION OF APPROPRIATIONS.**—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of the Social Security Act) of not more than the following amounts to carry out the demonstration project established under subsection (a) (without regard to amounts appropriated in advance in appropriation Acts):

(1) For fiscal year 1991, \$4,000,000.

(2) For fiscal year 1992, \$4,000,000.

(3) For fiscal year 1993, \$3,000,000.

(4) For fiscal year 1994, \$2,000,000.

(5) For fiscal year 1995, \$1,000,000.

SEC. 4203. EXTENSION OF SECONDARY PAYOR PROVISIONS.

(a) **EXTENSION OF TRANSFER OF DATA.**—

(1) Section 1862(b)(5)(C)(iii) (42 U.S.C. 1395y(b)(5)(C)(iii)) is amended by striking "September 30, 1991" and inserting "September 30, 1995".

(2) Section 6103(l)(12)(F) of the Internal Revenue Code of 1986 is amended—

(A) in clause (i), by striking "September 30, 1991" and inserting "September 30, 1995";

(B) in clause (ii)(I), by striking "1990" and inserting "1994"; and

(C) in clause (ii)(II), by striking "1991" and inserting "1995".

(b) **EXTENSION OF APPLICATION TO DISABLED BENEFICIARIES.**—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended by striking "January 1, 1992" and inserting "October 1, 1995".

(c) **INDIVIDUALS WITH END STAGE RENAL DISEASE.**—

(1) *IN GENERAL.*—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(A) in clause (i), by striking “during the 12-month period” and all that follows and inserting “during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and”

(B) in the matter following clause (ii), by adding at the end the following: “Effective for items and services furnished on or after February 1, 1991, and on or before January 1, 1996, (with respect to periods beginning on or after February 1, 1990), clauses (i) and (ii) shall be applied by substituting ‘18-month’ for ‘12-month’ each place it appears.”

(2) *GAO STUDY OF EXTENSION OF SECONDARY PAYER PERIOD.*—

(A) The Comptroller General shall conduct a study of the impact of the application of clause (iii) of section 1862(b)(1)(C) of the Social Security Act on individuals entitled to benefits under title XVIII of such Act by reason of section 226A of such Act, and shall include in such report information relating to—

(i) the number (and geographic distribution) of such individuals for whom medicare is secondary;

(ii) the amount of savings to the medicare program achieved annually by reason of the application of such clause;

(iii) the effect on access to employment, and employment-based health insurance, for such individuals and their family members (including coverage by employment-based health insurance of cost-sharing requirements under medicare after such employment-based insurance becomes secondary);

(iv) the effect on the amount paid for each dialysis treatment under employment-based health insurance;

(v) the effect on cost-sharing requirements under employment-based health insurance (and on out-of-pocket expenses of such individuals) during the period for which medicare is secondary;

(vi) the appropriateness of applying the provisions of section 1862(b)(1)(C) to all group health plans.

(B) The Comptroller General shall submit a preliminary report on the study conducted under subparagraph (A) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate not later than January 1, 1993, and a final report on such study not later than January 1, 1995.

(d) *EFFECTIVE DATE.*—The amendments made by this subsection shall take effect on the date of the enactment of this Act and the amendment made by subsection (a)(2)(B) shall apply to requests made on or after such date.

SEC. 4204. HEALTH MAINTENANCE ORGANIZATIONS.

(a) REGULATION OF INCENTIVE PAYMENTS TO PHYSICIANS.—

(1) IN GENERAL.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

“(8)(A) Each contract with an eligible organization under this section shall provide that the organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

“(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

“(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

“(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

“(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

“(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

“(B) In this paragraph, the term ‘physician incentive plan’ means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.”

(2) PENALTIES.—Section 1876(i)(6)(A)(vi) (42 U.S.C. 1395mm(i)(6)(A)(vi)) is amended by striking “(g)(6)(A);” and inserting “(g)(6)(A) or paragraph (8);”.

(3) REPEAL OF PROHIBITION.—Section 1128A(b)(1) (42 U.S.C. 1320a-7a(b)(1)) is amended—

(A) by striking “, an eligible organization” and all that follows through “section 1876,”

(B) by adding “and” at the end of subparagraph (A),

(C) by striking subparagraph (B),

(D) by redesignating subparagraph (C) as subparagraph (B), and

(E) by striking “or organization”.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply with respect to contract years beginning on or after January 1, 1992, and the amendments made by paragraph (3) shall take effect on the date of the enactment of this Act.

(b) **REQUIREMENTS WITH RESPECT TO ACTUARIAL EQUIVALENCE OF AAPCC.**—(1) Not later than January 1, 1992, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall submit a proposal to Congress that provides for a modified payment method for organizations with a risk contract under section 1876(g) of the Social Security Act that is more accurate than the current payment methodology in predicting the actual service utilization and annual medical expenditures of the beneficiary population enrolled in a specific organization.

(2) The proposal shall include—

(A)(i) recommendations on modifying the current adjusted average per capita cost formula, by adding predictors of medical utilization such as health status adjustors or prior utilization measures; or

(ii) recommendations for a new payment methodology as an alternative to the adjusted average per capita cost;

(B) data to support any recommended changes in payment methodology for organizations with risk contracts under section 1876(g) of the Social Security Act; and

(C) analysis demonstrating that any proposed or revised payment methodology under this section is effective in explaining at least 15 percent of the variation in health care utilization and costs (as determined in consultation with the American Academy of Actuaries) among individuals enrolled in such organizations.

(3) Not later than March 1, 1992, the Secretary shall cause to have published in the Federal Register a proposed rule providing for the implementation of the payment methodology specified in the proposal submitted pursuant to paragraph (1).

(4) Not later than May 1, 1992, the Comptroller General shall review the proposal and recommendations made pursuant to paragraphs (1) and (2), and shall report to Congress on appropriate modifications in such payment methodology.

(5) Taking into account the recommendations made pursuant to paragraph (4), on or after August 1, 1992, the Secretary shall issue a final rule implementing a payment methodology that meets the requirements of paragraph (1), effective for contract years beginning on or after January 1, 1993.

(c) **APPLICATION OF NATIONAL COVERAGE DECISIONS.**—

(1) **IN GENERAL.**—Section 1876(c)(2) (42 U.S.C. 1395mm(c)(2)) is amended—

(A) by redesignating clauses (i) and (ii) and subparagraphs (A) and (B) as subclauses (I) and (II) and clauses (i) and (ii), respectively;

(B) by inserting "(A)" after "(2)"; and

(C) by adding at the end the following new subparagraph:

"(B) If there is a national coverage determination made in the period beginning on the date of an announcement under subsection (a)(1)(A) and ending on the date of the next announcement under such subsection that the Secretary projects will result in a significant change in the costs to the organization of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the per

capita rate of payment included in the announcement made at the beginning of such period—

“(i) such determination shall not apply to risk-sharing contracts under this section until the first contract year that begins after the end of such period; and

“(ii) if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.”.

(2) **CONFORMING AMENDMENT.**—Section 1876(a)(6) of such Act is amended by striking “subsection (c)(7)” and inserting “subsections (c)(2)(B)(ii) and (c)(7)”.

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply with respect to national coverage determinations that are not incorporated in the determination of the per capita rate of payment for individuals enrolled for 1991 with an eligible organization which has entered into a risk-sharing contract under section 1876 of the Social Security Act.

(d) **PAYMENTS FOR SERVICES FURNISHED BY NON-CONTRACT PROVIDERS.**—

(1) **IN GENERAL.**—Section 1876(j) (42 U.S.C. 1395mm(j)) is amended—

(A) in paragraph (1)(A)—

(i) by striking “physician” each place it appears and inserting “physician or provider of services or renal dialysis facility”,

(ii) by striking “physicians’ services” and inserting “physicians’ services or renal dialysis services”, and

(iii) by striking “participation agreement under section 1842(h)(1)” and inserting “applicable participation agreement”,

(B) in paragraph (2)—

(i) by striking “physicians’ services” each place it appears and inserting “physicians’ services or renal dialysis services”, and

(ii) by striking “which—” and all that follows and inserting “which are furnished to an enrollee of an eligible organization under this section by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to items and services furnished on or after January 1, 1991.

(e) **RETROACTIVE ENROLLMENT.**—

(1) **IN GENERAL.**—Section 1876(a)(1)(E) (42 U.S.C. 1395mm(a)(1)(E)) is amended—

(A) by striking “(E)” and inserting “(E)(i)”; and

(B) by adding at the end the following new clause:

“(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals

enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to, by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

"(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) at the time the individual enrolled with the organization."

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply with respect to individuals enrolling with an eligible organization (which has a risk-sharing contract under section 1876 of the Social Security Act) under a health benefit plan operated, sponsored, or contributed to, by the individual's employer or former employer (or the employer or former employer of the individual's spouse) on or after January 1, 1991.

(f) **STUDY OF CHIROPRACTIC SERVICES.**—

(1) The Secretary shall conduct a study of the extent to which health maintenance organizations with contracts under section 1876 of the Social Security Act make available to enrollees entitled to benefits under title XVIII of such Act chiropractic services that are covered under such title.

(2) The study shall examine the arrangements under which such services are made available and the types of practitioners furnishing such services to such enrollees.

(3) The study shall be based on contracts entered into or renewed on or after January 1, 1991, and before January 1, 1993.

(4) The Secretary shall issue a final report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the results of the study not later than January 1, 1993. The report shall include recommendations with respect to any legislative and regulatory changes that the Secretary determines are necessary to ensure access to such services.

(g) **PROHIBITING CERTAIN EMPLOYER MARKETING ACTIVITIES.**—

(1) **IN GENERAL.**—Section 1862(b)(3) (42 U.S.C. 1395y(b)(3)) is amended by adding at the end the following new subparagraph:

"(C) **PROHIBITION OF FINANCIAL INCENTIVES NOT TO ENROLL IN A GROUP HEALTH PLAN.**—It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under this title not to enroll (or to terminate enrollment) under a group health plan which would (in the case of such enrollment) be a primary plan (as defined in paragraph (2)(A)), unless such incentive is also offered to all individuals who are eligible for coverage under the plan. Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed \$5,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to

a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).”

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to incentives offered on or after the date of the enactment of this Act.

SEC. 4205. PEER REVIEW ORGANIZATIONS.

(a) USE OF CORRECTIVE ACTION PLANS.—

(1) **IN GENERAL.**—Section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended—

(A) by inserting “and, if appropriate, after the practitioner or person has been given a reasonable opportunity to enter into and complete a corrective action plan (which may include remedial education) agreed to by the organization, and has failed successfully to complete such plan,” after “concerned,”; and

(B) by inserting after the second sentence the following: “In determining whether a practitioner or person has demonstrated an unwillingness or lack of ability substantially to comply with such obligations, the Secretary shall consider the practitioner’s or person’s willingness or lack of ability, during the period before the organization submits its report and recommendations, to enter into and successfully complete a corrective action plan.”

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to initial determinations made by organizations on or after the date of the enactment of this Act.

(b) TREATMENT OF OPTOMETRISTS AND PODIATRISTS.—

(1) **IN GENERAL.**—Section 1154 (42 U.S.C. 1320c-3) is amended—

(A) in subsection (a)(7)(A)(i), by inserting “, optometry, and podiatry” after “dentistry”; and

(B) in subsection (c), by striking “or dentistry” each place it appears and inserting “dentistry, optometry, or podiatry”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to contracts entered into or renewed on or after the date of the enactment of this Act.

(c) COORDINATION OF PROS AND CARRIERS.—

(1) **DEVELOPMENT AND IMPLEMENTATION OF PLAN.**—The Secretary of Health and Human Services shall develop and implement a plan to coordinate the physician review activities of peer review organizations and carriers. Such plan shall include—

(A) the development of common utilization and medical review criteria;

(B) criteria for the targeting of reviews by peer review organizations and carriers; and

(C) improved methods for exchange of information among peer review organizations and carriers.

(2) **REPORT.**—Not later than January 1, 1992, the Secretary shall submit to Congress a report on the development of the plan described under paragraph (1) and shall include in the report such recommendations for changes in legislation as may be appropriate.

(d) *PEER REVIEW NOTICE.*—(1) *NOTICE OF PROPOSED SANCTIONS.*—(A) *REQUIREMENT.*—Section 1154(a)(9) (42 U.S.C. 1320c-3(a)(9)) is amended—

(i) by inserting “(A)” after “(9)”; and

(ii) by adding at the end the following:

“(B) If the organization finds, after notice and hearing, that a physician has furnished services in violation of this subsection, the organization shall notify the State board or boards responsible for the licensing or disciplining of the physician of its finding and decision.”

(B) *DISCLOSURE.*—Section 1160(b)(1) (42 U.S.C. 1320c-9(b)(1)) is amended—

(i) by striking “and” at the end of subparagraph (B),

(ii) by adding “and” at the end of subparagraph (C),

and

(iii) by adding at the end the following new subparagraph:

“(D) to provide notice to the State medical board in accordance with section 1154(a)(9)(B) when the organization submits a report and recommendations to the Secretary under section 1156(b)(1) with respect to a physician whom the board is responsible for licensing;”

(C) *EFFECTIVE DATE.*—The amendments made by this paragraph shall apply to notices of proposed sanctions issued more than 60 days after the date of the enactment of this Act.(2) *NOTICE TO STATE MEDICAL BOARDS WHEN ADVERSE ACTIONS TAKEN BY SECRETARY.*—(A) *IN GENERAL.*—Section 1156(b) (42 U.S.C. 1320c-5(b)) is amended by adding at the end the following new paragraph:

“(6) When the Secretary effects an exclusion of a physician under paragraph (2), the Secretary shall notify the State board responsible for the licensing of the physician of the exclusion.”

(B) *EFFECTIVE DATE.*—The amendments made by this paragraph shall apply to sanctions effected more than 60 days after the date of the enactment of this Act.(e) *CONFIDENTIALITY OF PEER REVIEW DELIBERATIONS.*—

(1) *IN GENERAL.*—Section 1160(d) (42 U.S.C. 1320c-9(d)) is amended by adding at the end the following: “No document or other information produced by such an organization in connection with its deliberations in making determinations under section 1154(a)(1)(B) or 1156(a)(2) shall be subject to subpoena or discovery in any administrative or civil proceeding; except that such an organization shall provide, upon request of a practitioner or other person adversely affected by such a determination, a summary of the organization’s findings and conclusions in making the determination.”

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply to all proceedings as of the date of the enactment of this Act.

(f) *CLARIFICATION OF LIMITATION ON LIABILITY.*—Section 1157(b) (42 U.S.C. 1320c-6(b)) is amended—

(1) by inserting "organization having a contract with the Secretary under this part and no" after "No",

(2) by striking "by him", and

(3) by striking "he has exercised due care" and inserting "due care was exercised in the performance of such duty, function, or activity".

(g) MISCELLANEOUS AND TECHNICAL AMENDMENTS RELATING TO PEER REVIEW ORGANIZATIONS.—

(1) CLARIFICATION OF PATIENT NOTIFICATION REQUIREMENTS FOR DENIAL OF PAYMENT BY PRO.—

(A) IN GENERAL.—Section 1154(a)(3)(E) (42 U.S.C. 1320c-3(a)(3)(E)) is amended—

(i) by striking "(E)" and inserting "(E)(i)";

(ii) by inserting after "items" the following: "provided by a physician that were";

(iii) by striking "physician and hospital." and inserting "physician."; and

(iv) by adding at the end the following new clause:

"(ii) In the case of services or items provided by an entity or practitioner other than a physician, the Secretary may substitute the entity or practitioner which provided the services or items for the term 'physician' in the notice described in clause (i)."

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

(2) CLARIFICATION OF APPLICATION OF CRITERIA FOR DENIAL OF PAYMENT.—

(A) IN GENERAL.—Section 1154(a)(2) (42 U.S.C. 1320c-3(a)(2)) is amended by striking the third sentence and inserting the following: "The organization shall identify cases for which payment should not be made by reason of paragraph (1)(B) only through the use of criteria developed pursuant to guidelines established by the Secretary."

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

SEC. 4206. MEDICARE PROVIDER AGREEMENTS ASSURING THE IMPLEMENTATION OF A PATIENT'S RIGHT TO PARTICIPATE IN AND DIRECT HEALTH CARE DECISIONS AFFECTING THE PATIENT.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subsection (a)(1)—

(A) by striking "and" at the end of subparagraph (O),

(B) by striking the period at the end of subparagraph (P) and inserting "; and", and

(C) by inserting after subparagraph (P) the following new subparagraph:

"(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives)."; and

(2) by inserting after subsection (e) the following new subsection:

“(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(r), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

“(A) to provide written information to each such individual concerning—

“(i) an individual’s rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

“(ii) the written policies of the provider or organization respecting the implementation of such rights;

“(B) to document in the individual’s medical record whether or not the individual has executed an advance directive;

“(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

“(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization; and

“(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

“(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

“(A) in the case of a hospital, at the time of the individual’s admission as an inpatient,

“(B) in the case of a skilled nursing facility, at the time of the individual’s admission as a resident,

“(C) in the case of a home health agency, in advance of the individual coming under the care of the agency,

“(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

“(E) in the case of an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A), at the time of enrollment of the individual with the organization.

“(3) In this subsection, the term ‘advance directive’ means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.”.

(b) APPLICATION TO PREPAID ORGANIZATIONS.—

(1) *ELIGIBLE ORGANIZATIONS.*—Section 1876(c) of such Act (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

“(8) A contract under this section shall provide that the eligible organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).”.

(2) *OTHER PREPAID ORGANIZATIONS.*—Section 1833 of such Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

“(r) The Secretary may not provide for payment under subsection (a)(1)(A) with respect to an organization unless the organization provides assurances satisfactory to the Secretary that the organization meets the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).”.

(c) *EFFECT ON STATE LAW.*—Nothing in subsections (a) and (b) shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which, as a matter of conscience, cannot implement an advance directive.

(d) *CONFORMING AMENDMENTS.*—

(1) Section 1819(c)(1) of such Act (42 U.S.C. 1395i-3(c)(1)) is amended by adding at the end the following new subparagraph:

“(E) *INFORMATION RESPECTING ADVANCE DIRECTIVES.*—A skilled nursing facility must comply with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).”.

(2) Section 1891(a) of such Act (42 U.S.C. 1395bbb(a)) is amended by adding at the end the following:

“(6) The agency complies with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).”.

(e) *EFFECTIVE DATES.*—

(1) The amendments made by subsections (a) and (d) shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act.

(2) The amendments made by subsection (b) shall apply to contracts under section 1876 of the Social Security Act and payments under section 1833(a)(1)(A) of such Act as of first day of the first month beginning more than 1 year after the date of the enactment of this Act.

SEC. 4027. MISCELLANEOUS AND TECHNICAL PROVISIONS RELATING TO PARTS A AND B.

(a) *HOSPITAL AND PHYSICIAN OBLIGATIONS WITH RESPECT TO EMERGENCY MEDICAL CONDITIONS.*—

(1) *PEER REVIEW.*—(A) Section 1867(d) (42 U.S.C. 1395dd(d)), as amended by section 4008(b)(3), is amended by adding at the end the following new paragraph:

“(3) *CONSULTATION WITH PEER REVIEW ORGANIZATIONS.*—In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control

peer review organization (with a contract under part B of title XI) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(B) Section 1154(a) (42 U.S.C. 1320c-4(a)) is amended by adding at the end the following new paragraph:

"(16) The organization shall provide for a review and report to the Secretary when requested by the Secretary under section 1867(d)(3). The organization shall provide reasonable notice of the review to the physician and hospital involved. Within the time period permitted by the Secretary, the organization shall provide a reasonable opportunity for discussion with the physician and hospital involved, and an opportunity for the physician and hospital to submit additional information, before issuing its report to the Secretary under such section."

(C) The amendment made by subparagraph (A) shall take effect on the first day of the first month beginning more than 60 days after the date of the enactment of this Act. The amendment made by subparagraph (B) shall apply to contracts under part B of title XI of the Social Security Act as of the first day of the first month beginning more than 60 days after the date of the enactment of this Act.

(2) CIVIL MONETARY PENALTIES.—Section 1867(d)(2)(B) (42 U.S.C. 1395dd(d)(2)(B)) is amended by striking "knowingly" and inserting "negligently".

(3) EXCLUSION.—Section 1867(d)(2)(B) (42 U.S.C. 1395dd(d)(2)(B)) is amended by striking "knowing and willful or negligent" and inserting "is gross and flagrant or is repeated".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to actions occurring on or after the first day of the sixth month beginning after the date of the enactment of this Act.

(b) EXTENSIONS OF EXPIRING PROVISIONS.—

(1) PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may not issue any proposed or final regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act in a fiscal year (beginning with fiscal year 1991 and ending with fiscal year 1993, or, if later, the last fiscal year for which there is a maximum deficit amount specified under section 3(7) of the Congressional Budget and Impoundment Control Act of 1974) of more than \$50,000,000, except as follows:

(A) The Secretary may issue such a proposed regulation, instruction, or other policy with respect to the fiscal year before the May 15 preceding the beginning of the fiscal year.

(B) The Secretary may issue such a final regulation, instruction, or other policy with respect to the fiscal year on or after October 15 of the fiscal year.

(C) The Secretary may, at any time, issue such a proposed or final regulation, instruction, or other policy with respect to the fiscal year if required to implement specific provisions under statute.

(2) **PROHIBITION OF PAYMENT CYCLE CHANGES.**—Notwithstanding any other provision of law, the Secretary of Health and Human Services is not authorized to issue, after the date of the enactment of this Act, any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down or speeding up claims processing, or delaying payment of claims, under title XVIII of the Social Security Act.

(3) **WAIVER OF LIABILITY FOR HOME HEALTH AGENCIES.**—Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988, is amended by striking “November 1, 1990” and inserting “December 31, 1995”.

(4) **EXTENSION AND EXPANSION OF WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.**—

(A) **EXTENSION OF CURRENT WAIVERS.**—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(i) in paragraph (1), by striking “September 30, 1992” and inserting “December 31, 1995”; and

(ii) in paragraph (4)—

(I) by striking “final” and inserting “second interim”, and

(II) by striking the period at the end and inserting the following: “, and shall submit a final report on the demonstration projects conducted under section 2355 of the Deficit Reduction Act of 1984 not later than March 31, 1996.”.

(B) **EXPANSION OF DEMONSTRATIONS.**—Section 2355 of the Deficit Reduction Act of 1984 is amended—

(i) in subsection (a), by adding at the end the following: “Not later than 12 months after the date of the enactment of the Omnibus Budget Reconciliation Act of 1990, the Secretary shall approve such applications or protocols for not more than 4 additional projects described in subsection (b).”;

(ii) by amending paragraph (1) of subsection (b) to read as follows:

“(1) to demonstrate—

“(A) the concept of a social health maintenance organization with the organizations as described in Project No. 18-P-9 7604/1-04 of the University Health Policy Consortium of Brandeis University, or

“(B) in the case of a project conducted as a result of the amendments made by section 12907(c)(4)(A) of the Omnibus Budget Reconciliation Act of 1990, the effectiveness and feasibility of innovative approaches to refining targeting

and financing methodologies and benefit design, including the effectiveness of feasibility of—

“(i) the benefits of expanded post-acute and community care case management through links between chronic care case management services and acute care providers;

“(ii) refining targeting or reimbursement methodologies;

“(iii) the establishment and operation of a rural services delivery system; or

“(iv) the effectiveness of second-generation sites in reducing the costs of the commencement and management of health care service delivery;”;

(iii) in subsection (b)—

(I) by inserting “and” at the end of paragraph (3),

(II) by striking the semicolon at the end of paragraph (4) and inserting a period, and

(III) by striking paragraphs (5), (6), and (7).

(iv) in subsection (c)—

(I) by striking “and” at the end of paragraph (1),

(II) by striking the period at the end of paragraph (2) and inserting “; and”, and

(III) by adding at the end the following new paragraph:

“(3) in the case of a project conducted as a result of the amendments made by section 12907(c)(4)(A) of the Omnibus Budget Reconciliation Act of 1990, any requirements of titles XVIII or XIX of the Social Security Act that, if imposed, would prohibit such project from being conducted.”; and

(v) by adding at the end the following new subsection:

“(e) There are authorized to be appropriated \$3,500,000 for the costs of technical assistance and evaluation related to projects conducted as a result of the amendments made by section 12907(c)(4)(A) of the Omnibus Budget Reconciliation Act of 1990.”.

(c) DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.—

(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which payment is made for home health services under title XVIII of the Social Security Act or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the medicare program;

(B) provide for adjustments to prospectively determined rates to account for changes in a provider's case mix, severity of illness of patients, volume of cases, and the develop-

ment of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of treatment or costs of treatment greatly exceed the length or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as differences in wages and wage-related costs among agencies located in various geographic areas and other factors the Secretary considers appropriate; and

(E) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments under the system.

(2) **REPORTS.**—(A) By not later than April 1, 1993, the Secretary of Health and Human Services shall submit the research findings upon which the proposal described in paragraph (1) shall be based to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than September 1, 1993, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(C) By not later than March 1, 1994, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(d) **HOME HEALTH WAGE INDEX.**—

(1) **IN GENERAL.**—Section 1861(v)(1)(L)(iii) of (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended to read as follows:

“(iii) Not later than July 1, 1991, and annually thereafter, the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) as of such date to hospitals located in the geographic area in which the home health agency is located (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B), a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10), or a decision of the Secretary).”

(2) **APPLICATION ON BUDGET-NEUTRAL BASIS.**—In updating the wage index for establishing limits under section 1861(v)(1)(L)(iii) of the Social Security Act, the Secretary shall ensure that aggregate payments to home health agencies under title XVIII of such Act will be no greater or lesser than such payments would have been without regard to such update.

(3) **TRANSITION PROVISION.**—Notwithstanding section 1861(v)(1)(L)(iii) of the Social Security Act, the Secretary of Health and Human Services shall, in determining the limits of reasonable costs under title XVIII of such Act with respect to

services furnished by a home health agency, utilize a wage index equal to—

(A) for cost reporting periods beginning on or after July 1, 1991, and on or before June 30, 1992, a combined area wage index consisting of—

(i) 67 percent of the area wage index applicable under section 1861(v)(1)(L)(iii) of such Act to such home health agency, determined using the survey of the 1982 wages and wage-related costs of hospitals in the United States conducted under such section, and

(ii) 33 percent of the area wage index applicable under section 1886(d)(3)(E) of such Act to hospitals located in the geographic area in which the home health agency is located, determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section; and

(B) for cost reporting periods beginning on or after July 1, 1992, and on or before June 30, 1993, a combined area wage index consisting of—

(i) 33 percent of the area wage index applicable under section 1861(v)(1)(L)(iii) of such Act to such home health agency, determined using the survey of the 1982 wages and wage-related costs of hospitals in the United States conducted under such section, and

(ii) 67 percent of the area wage index applicable under section 1886(d)(3)(E) of such Act to hospitals located in the geographic area in which the home health agency is located, determined using the survey of the 1988 wages and wage-related costs of hospitals in the United States conducted under such section.

(4) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply with respect to home health agency cost reporting periods beginning on or after July 1, 1991.

(e) **CLARIFICATION OF DEFINITIONS AND REPORTING REQUIREMENTS RELATING TO PHYSICIAN OWNERSHIP AND REFERRAL.**—

(1) **CLARIFYING DEFINITIONS.**—Section 1877(h) of the Social Security Act (42 U.S.C. 1395nn(h)) is amended—

(A) in paragraph (6)(A), by striking “in the case of” and all that follows through “the service,” and inserting “in the case of an item or service for which payment may be made under part B, the request by a physician for the item or service,”;

(B) in paragraph (6)(B), by striking “in the case of another clinical laboratory service,” and

(C) by redesignating paragraph (6) as paragraph (7) and by inserting after paragraph (5) the following new paragraph:

“(6) **INVESTOR.**—The term ‘investor’ means, with respect to an entity, a person with a financial relationship specified in subsection (a)(2) with the entity.”

(2) **EXEMPTION FOR FINANCIAL RELATIONSHIPS WITH HOSPITAL UNRELATED TO THE PROVISION OF CLINICAL LABORATORY SERVICES.**—Section 1877(b) is amended by redesignating paragraph

(4) as paragraph (5) and by inserting after paragraph (3) the following new paragraph:

"(4) **HOSPITAL FINANCIAL RELATIONSHIP UNRELATED TO THE PROVISION OF CLINICAL LABORATORY SERVICES.**—In the case of a financial relationship with a hospital if the financial relationship does not relate to the provision of clinical laboratory services."

(3) **REVISION OF REPORTING REQUIREMENTS.**—Section 1877(f) (42 U.S.C. 1395nn(f)) is amended—

(A) by amending paragraph (2) to read as follows:

"(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)) in the entity, or whose immediate relatives have such an ownership or investment.";

(B) in the third sentence, by striking "1 year after the date of the enactment of this section" and inserting "October 1, 1991"; and

(C) by adding at the end the following new sentences:
 "The requirement of this subsection shall not apply to covered items and services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this title very infrequently. The Secretary may waive the requirements of this subsection (and the requirements of chapter 35 of title 44, United States Code, with respect to information provided under this subsection) with respect to reporting by entities in a State (except for entities providing clinical laboratory services) so long as such reporting occurs in at least 10 States, and the Secretary may waive such requirements with respect to the providers in a State required to report so long as such requirements are not waived with respect to parenteral and enteral suppliers, end stage renal disease facilities, suppliers of ambulance services, hospitals, entities providing physical therapy services, and entities providing diagnostic imaging services of any type."

(4) **DATE OF ISSUANCE OF REPORTS AND REGULATIONS.**—(A) Section 6204 of the Omnibus Budget Reconciliation Act of 1989 is amended by striking subsection (f) and inserting the following:

"(f) **STATISTICAL SUMMARY OF COMPARATIVE UTILIZATION.**—Not later than June 30, 1992, the Secretary of Health and Human Services shall submit to Congress a statistical profile comparing utilization of items and services by medicare beneficiaries served by entities in which the referring physician has a direct or indirect financial interest and by medicare beneficiaries served by other entities, for the States and entities specified in section 1877(f) of the Social Security Act (other than entities providing clinical laboratory services)."

(B) Section 6204(d) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking "October 1, 1990" and inserting "October 1, 1991".

(5) **EFFECTIVE DATE.**—The amendments made by this subsection shall be effective as if included in the enactment of section 6204 of the Omnibus Budget Reconciliation Act of 1989.

(g) **CASE MANAGEMENT DEMONSTRATION PROJECT.**—

(1) **IN GENERAL.**—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall resume the 3 case management demonstration projects described in paragraph (2) and approved under section 425 of the Medicare Catastrophic Coverage Act of 1988 (in this subsection referred to as “MCCA”).

(2) **PROJECT DESCRIPTIONS.**—The demonstration projects referred to in paragraph (1) are—

(A) the project proposed to be conducted by Providence Hospital for case management of the elderly at risk for acute hospitalization as described in Project No. 18-P-99379/5-01;

(B) the project proposed to be conducted by the Iowa Foundation for Medical Care to study patients with chronic congestive conditions to reduce repeated hospitalizations of such patients as described in Project No. P-99399/4-01; and

(C) the project proposed to be conducted by Key Care Health Resources, Inc., to examine the effects of case management on 2,500 high cost medicare beneficiaries as described in Project No. 18-P-99396/5.

(3) **TERMS AND CONDITIONS.**—Except as provided in paragraph (4), the demonstration projects resumed pursuant to paragraph (1) shall be subject to the same terms and conditions established under section 425 of MCCA. In determining the 2-year duration period of a project resumed pursuant to paragraph (1), the Secretary may not take into account any period of time for which the project was in effect under section 425 of MCCA.

(4) **AUTHORIZATION OF APPROPRIATIONS.**—Notwithstanding section 425(g) of MCCA, there are authorized to be appropriated for administrative costs in carrying out the demonstration projects resumed pursuant to paragraph (1) \$2,000,000 in each of fiscal years 1991 and 1992.

(h) **PROHIBITION OF USER FEES FOR SURVEY AND CERTIFICATION.**—Section 1864 (42 U.S.C. 1395aa) is amended by adding at the end the following new subsection:

“(e) Notwithstanding any other provision of law, the Secretary may not impose, or require a State to impose, any fee on any facility or entity subject to a determination under subsection (a), or any renal dialysis facility subject to the requirements of section 1881(b)(1), for any such determination or any survey relating to determining the compliance of such facility or entity with any requirement of this title.”.

(i) **DELEGATION OF AUTHORITY TO INSPECTOR GENERAL.**—Section 1128A(j) (42 U.S.C. 1320a-7a(j)) is amended—

(i) by striking “(j)” and inserting “(j)(1)”; and

(ii) by adding at the end the following new paragraph:

“(2) The Secretary may delegate authority granted under this section and under section 1128 to the Inspector General of the Department of Health and Human Services.”.

(j) **MODIFICATION OF HOME HEALTH AGENCY DEFICIENCY STANDARDS.**—

(1) **IN GENERAL.**—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section

1891(a)(3)(D)(iii) of the Social Security Act (42 U.S.C. 1395bbb(a)(3)(D)(iii)) is amended by striking "which has been determined" and all that follows and inserting the following: "which, within the previous 2 years—

"(I) has been determined to be out of compliance with subparagraph (A), (B), or (C);

"(II) has been subject to an extended (or partial extended) survey under subsection (c)(2)(D);

"(III) has been assessed a civil money penalty described in subsection (f)(2)(A)(i) of not less than \$5,000; or

"(IV) has been subject to the remedies described in subsection (e)(1) or in clauses (ii) or (iii) of subsection (f)(2)(A).".

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, except that the Secretary may not permit approval of a training and competency evaluation program or a competency evaluation program offered by or in a home health agency which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

(i) had its participation terminated under title XVIII of the Social Security Act;

(ii) was assessed a civil money penalty not less than \$5,000 for deficiencies in applicable quality standards for home health agencies;

(iii) was subject to suspension by the Secretary of all or part of the payments to which it would otherwise be entitled under such title.

(iv) operated under a temporary management appointed to oversee the operation of the agency and to ensure the health and safety of the agency's patients; or

(v) pursuant to State action, was closed or had its residents transferred.

(k) **USE OF INTERIM FINAL REGULATIONS.**—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this title and the amendments made by this title.

(m) **MISCELLANEOUS TECHNICAL CORRECTIONS.**—

(1) The third sentence of subsections (a) and (b)(1) of section 1882 of the Social Security Act (42 U.S.C. 1395ss), as amended by section 203(a)(1)(A) of the Medicare Catastrophic Coverage Repeal Act, is amended by striking "(k)(4).".

(2) Section 1877(g)(5) of the Social Security Act, as added by section 6204(a) of OBRA-1989, is amended by adding at the end the following new sentence: "The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(3) Subsection (i) of section 1867 of the Social Security Act, as added by section 6211(f) of the Omnibus Budget Reconciliation Act of 1989, is amended to read as follows:

"(i) **WHISTLEBLOWER PROTECTIONS.**—A participating hospital may not penalize or take adverse action against a qualified medical

person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section."

(4) Section 6213(d) of the Omnibus Budget Reconciliation Act of 1989 is amended by striking "take effect" and inserting "apply to services furnished on or after".

(5) Section 6217(a) of the Omnibus Budget Reconciliation Act of 1989 is amended in the matter preceding paragraph (1) by inserting after "payments" the following: "out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate in a year)".

(6) Section 1139(d) of the Social Security Act, as amended by section 6221 of Omnibus Budget Reconciliation Act of 1989, is amended by striking "interim report" and all that follows through "setting forth" and inserting the following: "interim report no later than March 31, 1990, and a final report no later than March 31, 1991, setting forth".

PART 4—PROVISIONS RELATING TO MEDICARE PART B PREMIUM AND DEDUCTIBLE

SEC. 4301. PART B PREMIUM.

Section 1839(e)(1) (42 U.S.C. 1395r(e)(1)) is amended—

(1) by inserting "(A)" after "(e)(1)", and

(2) by adding at the end the following new subparagraph:

"(B) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month in—

"(i) 1991 shall be \$29.90,

"(ii) 1992 shall be \$31.80,

"(iii) 1993 shall be \$36.60,

"(iv) 1994 shall be \$41.10, and

"(v) 1995 shall be \$46.10."

SEC. 4302. PART B DEDUCTIBLE.

Section 1833(b) (42 U.S.C. 1395l) is amended by inserting after "\$75" the following: "for calendar years before 1991 and \$100 for 1991 and subsequent years".

PART 5—MEDICARE SUPPLEMENTAL INSURANCE POLICIES

SEC. 4351. SIMPLIFICATION OF MEDICARE SUPPLEMENTAL POLICIES.

(a) *IN GENERAL.*—Section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subsection (b)(1)(B), by striking "through (4)" and inserting "through (5)";

(2) in subsection (c)—

(A) by striking "and" at the end of paragraph (3),

(B) by striking the period at the end of paragraph (4) and inserting "; and", and

(C) by inserting after paragraph (4) the following new paragraph:

"(5) meets the applicable requirements of subsections (o) through (t)."; and

(3) by adding at the end the following new subsections:

"(o) The requirements of this subsection are as follows:

"(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsection (p).

"(2) If the medicare supplemental policy provides for coverage of a group of benefits other than the core group of basic benefits described in subsection (p)(2)(B), the issuer of the policy must make available to the individual a medicare supplemental policy with only such core group of basic benefits.

"(3) The issuer of the policy has provided, before the sale of the policy, an outline of coverage that uses uniform language and format (including layout and print size) that facilitates comparison among medicare supplemental policies and comparison with medicare benefits.

"(p)(1)(A) If, within 9 months after the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the 'Association') promulgates—

"(i) limitations on the groups or packages of benefits that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection,

"(ii) uniform language and definitions to be used with respect to such benefits,

"(iii) uniform format to be used in the policy with respect to such benefits, and

"(iv) other standards to meet the additional requirements imposed by the amendments made by the Omnibus Budget Reconciliation Act of 1990,

(such limitations, language, definitions, format, and standards referred to collectively in this subsection as 'NAIC standards'), subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, included a reference to the NAIC standards.

"(B) If the Association does not promulgate NAIC standards within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, limitations, language, definitions, format, and standards described in clauses (i) through (iv) of such subparagraph (in this subsection referred to collectively as 'Federal standards') and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policyholders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, included a reference to the Federal standards.

"(C)(i) Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the NAIC standards or the Federal standards or 1 year after the date the Association or the Secretary first adopts such standards, whichever is earlier.

"(ii) In the case of a State which the Secretary identifies, in consultation with the Association, as—

"(I) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet the NAIC or Federal standards, but

"(II) having a legislature which is not scheduled to meet in 1992 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(E) In promulgating standards under this paragraph, the Association or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

"(F) If benefits (including deductibles and coinsurance) under this title are changed and the Secretary determines, in consultation with the Association, that changes in the NAIC or Federal standards are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

"(2) The benefits under the NAIC or Federal standards shall provide—

"(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

"(B) for identification of a core group of basic benefits common to all policies, and

"(C) that, subject to paragraph (5)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10.

"(3) The benefits under paragraph (2) shall, to the extent possible—

"(A) provide for benefits that offer consumers the ability to purchase the benefits that are available in the market as of the date of the enactment of this subsection; and

"(B) balance the objectives of (i) simplifying the market to facilitate comparisons among policies, (ii) avoiding adverse selection, (iii) providing consumer choice, (iv) providing market stability, and (v) promoting competition.

"(4)(A)(i) Except as provided in subparagraph (B), no State with a regulatory program approved under subsection (b)(1) may provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy unless such grouping meets the applicable standards.

"(ii) Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval by the Secretary unless such grouping meets the applicable standards.

"(B) With the approval of the State (in the case of a policy issued in a State with an approved regulatory program) or the Secretary (in the case of any other policy), the issuer of a medicare supplemental policy may offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the applicable standards. Any such new or innovative benefits may include benefits that are not otherwise available and are cost-effective and shall be offered in a manner which is consistent with the goal of simplification of medicare supplemental policies.

"(5)(A) Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State from restricting the groups of benefits that may be offered in medicare supplemental policies in the State.

"(B) A State with a regulatory program approved under subsection (b)(1) may not restrict under subparagraph (A) the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

"(6) The Secretary may waive the application of standards in regard to the limitation of benefits described in paragraph (4) in those States that on the date of enactment of this subsection had in place an alternative simplification program.

"(7) This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policyholder or certificateholders for the purchase of items or services not covered under its medicare supplemental policies.

"(8) Any person who sells or issues a medicare supplemental policy, after the effective date of the NAIC or Federal standards with respect to the policy, in violation of the previous requirements of this subsection is subject to a civil money penalty of not to exceed \$25,000 (or \$15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(9)(A) Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

"(B) Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the NAIC or Federal standards under this subsection.

"(C) Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed

\$25,000 (or \$15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(10) No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with this subsection."

SEC. 4352. GUARANTEED RENEWABILITY.

Section 1882 is amended by adding at the end the following new subsection:

"(q) The requirements of this subsection are as follows:

"(1) Each medicare supplemental policy shall be guaranteed renewable and—

"(A) the issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

"(B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

"(2) If the medicare supplemental policy is terminated by the group policyholder and is not replaced as provided under paragraph (2), the issuer shall offer certificateholders an individual medicare supplemental policy which (at the option of the certificateholder)—

"(A) provides for continuation of the benefits contained in the group policy, or

"(B) provides for such benefits as otherwise meets the requirements of this section.

"(3) If an individual is a certificateholder in a group medicare supplemental policy and the individual terminates membership in the group, the issuer shall—

"(A) offer the certificateholder the conversion opportunity described in paragraph (2), or

"(B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

"(4) If a group medicare supplemental policy is replaced by another group medicare supplemental policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced."

SEC. 4353. ENFORCEMENT OF STANDARDS.

(a) **REQUIRING CONFORMITY WITH STANDARDS.**—Section 1882 is amended—

(1) in the heading, by striking "voluntary"; and

(2) in subsection (a)—

(A) by inserting "(1)" after "(a)",

(B) by adding at the end the following new paragraph:

"(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(c) unless—

"(A) the State's regulatory program under subsection (b)(1) provides for the application and enforcement of the standards and requirements set forth in such subsection (including the NAIC standards or the Federal standards (as the case may be)) by the date specified in subsection (p)(1)(c); or

"(B) if the State's program does not provide for the application and enforcement of such standards and requirements, the policy has been certified by the Secretary under paragraph (1) as meeting the standards and requirements set forth in subsection (c) (including such applicable standards) by such date.

Any person who issues a medicare supplemental policy, after the effective date of the NAIC or Federal standards with respect to the policy, in violation of this paragraph is subject to a civil money penalty of not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a)."

(b) PERIODIC REVIEW OF STATE REGULATORY PROGRAMS.—Section 1882(b) is amended—

(1) in paragraph (1), by striking "Supplemental Health Insurance Panel (established under paragraph (2))" and inserting "the Secretary",

(2) in paragraph (1), by striking "the Panel" and inserting "the Secretary",

(3) in subparagraphs (A) and (D) of paragraph (1), by inserting "and enforcement" after "application", and

(4) by amending paragraph (2) to read as follows:

"(2) The Secretary periodically shall review State regulatory programs to determine if they continue to meet the standards and requirements specified in paragraph (1). If the Secretary finds that a State regulatory program no longer meets the standards and requirements, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State regulatory program to continue to meet such standards and requirements. If the Secretary makes a final determination that the State regulatory program, after such an opportunity, fails to meet such standards and requirements, the program shall no longer be considered to have in operation a program meeting such standards and requirements."

(c) ENFORCEMENT BY STATES.—Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by inserting "and" at the end of subparagraph (E);

(3) by inserting after subparagraph (E) the following:

"(F) reports to the Secretary on the implementation and enforcement of standards and requirements of this paragraph at intervals established by the Secretary,"; and

(5) by adding at the end the following new sentence: "The report required under subsection (F) shall include information on loss ratios of policies sold in the State, frequency and types of instances in which policies approved by the State fail to meet

the standards of this paragraph, actions taken by the State to bring such policies into compliance, and information regarding State programs implementing consumer protection provisions, and such further information as the Secretary in consultation with the National Association of Insurance Commissioners, may specify.”.

(d) **REQUIRING APPROVAL OF STATE FOR SALE IN THE STATE.**—

(1) **IN GENERAL.**—Section 1882(d)(4)(B) (42 U.S.C. 1395ss(d)(4)(B)) is amended by striking the second sentence.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to policies mailed, or caused to be mailed, on and after July 1, 1991.

SEC. 4354. PREVENTING DUPLICATION.

(a) **IN GENERAL.**—Subsection (d)(3) of section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subparagraph (A)—

(A) by striking “Whoever knowingly sells” and inserting “It is unlawful for a person to sell or issue”,

(B) by striking “substantially”,

(C) by striking “, shall be fined” and inserting “. Whoever violates the previous sentence shall be fined”,

(D) in subparagraph (A), by inserting “or title XIX” after “other than this title”,

(E) in subparagraph (A), by striking “\$5,000” and inserting “\$25,000 (or \$15,000 in the case of a person other than the issuer of the policy)”, and

(F) by adding at the end the following: “A seller (who is not the issuer of a health insurance policy) shall not be considered to violate the previous sentence if the policy is sold in compliance with subparagraph (B) and the statement under such subparagraph indicates on its face that the sale of the policy will not duplicate health benefits to which the individual is otherwise entitled. This subsection shall not apply to such a seller until such date as the Secretary publishes a list of the standardized benefit packages that may be offered consistent with subsection (p).”;

(2) by amending subparagraph (B) to read as follows:

“(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

“(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in subclause (II), a written statement signed by the individual stating, to the best of the individual’s knowledge, what health insurance policies the individual has, from what source, and whether the individual is entitled to any medical assistance under title XIX, whether as a qualified medicare beneficiary or otherwise, and

“(II) the written statement is accompanied by a written acknowledgment, signed by the seller of the policy, of the request for and receipt of such statement.

"(ii) The statement required by clause (i) shall be made on a form that—

"(I) states in substance that a medicare-eligible individual does not need more than one medicare supplemental policy,

"(II) states in substance that individuals 65 years of age or older may be eligible for benefits under the State medicaid program under title XIX and that such individuals who are entitled to benefits under that program usually do not need a medicare supplemental policy and that benefits and premiums under any such policy shall be suspended upon request of the policyholder during the period (of not longer than 24 months) of entitlement to benefits under such title and may be reinstituted upon loss of such entitlement, and

"(III) states that counseling services may be available in the State to provide advice concerning the purchase of medicare supplemental policies and enrollment under the medicaid program and may provide the telephone number for such services.

"(iii)(I) Except as provided in subclauses (II) and (III), if the statement required by clause (i) is not obtained or indicates that the individual has another medicare supplemental policy or indicates that the individual is entitled to any medical assistance under title XIX, the sale of such a policy shall be considered to be a violation of subparagraph (A).

"(II) Subclause (I) shall not apply in the case of an individual who has another policy, if the individual indicates in writing, as part of the application for purchase, that the policy being purchased replaces such other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective and the issuer or seller certifies in writing that such policy will not, to the best of the issuer or seller's knowledge, duplicate coverage (taking into account any such replacement).

"(III) Subclause (I) also shall not apply if a State medicaid plan under title XIX pays the premiums for the policy, or pays less than an individual's (who is described in section 1905(p)(1)) full liability for medicare cost sharing as defined in section 1905(p)(3)(A).

"(iv) Whoever issues or sells a medicare supplemental policy in violation of this subparagraph shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed \$25,000 (or \$15,000 in the case of a seller who is not the issuer of a policy) for each such violation."

(b) SUSPENSION OF POLICY DURING MEDICAID ENTITLEMENT.—Section 1882(q), as added by section 4352, is amended by adding at the end the following new paragraph:

"(2)(A) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder for the period (not to exceed 24 months) in which the policyholder has applied for and is determined to be entitled to medical assistance under title XIX of the Social Security Act, but only if the policyholder notifies the issuer of such policy within 90 days after the date the individual becomes entitled to such assistance. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy shall be automati-

cally reinstituted (effective as of the date of termination of such entitlement) under terms described in subsection (n)(6)(A)(ii) as of the termination of such entitlement if the policyholder provides notice of loss of such entitlement within 90 days after the date of such loss.

"(B) Nothing in this section shall be construed as affecting the authority of a State, under title XIX of the Social Security Act, to purchase a medicare supplemental policy for an individual otherwise entitled to assistance under such title.

"(C) Any person who issues a medicare supplemental policy and fails to comply with the requirements of this paragraph is subject to a civil money penalty of not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a)."

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to policies issued or sold more than 1 year after the date of the enactment of this Act.

SEC. 4355. LOSS RATIOS AND REFUND OF PREMIUMS.

(a) **IN GENERAL.**—Section 1882 (42 U.S.C. 1395ss) is further amended—

(1) in subsection (c), by amending paragraph (2) to read as follows:

"(2) meets the requirements of subsection (r);";

(2) by striking the sentence following subsection (c)(4); and

(3) by adding at the end the following new subsection:

"(r)(1) A medicare supplemental policy may not be issued or sold in any State unless—

"(A) the policy can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology, including uniform reporting standards, developed by the National Association of Insurance Commissioners, to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies; and

"(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (2), of the amount of premiums received necessary to assure that the ratio of aggregate benefits provided to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A).

For purposes of applying subparagraph (A) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

"(2)(A) Paragraph (1)(B) shall be applied with respect to each type of policy by policy number. Paragraph (1)(B) shall not apply to a policy with respect to the first 2 years in which it is in effect. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be appropriate in order to apply paragraph (1)(B) to the first 2 years in which policies are effective.

"(B) A refund or credit required under paragraph (1)(B) shall be made to each policyholder insured under the applicable policy as of the last day of the year involved.

"(C) Such a refund or credit shall include interest from the end of the policy year involved until the date of the refund or credit at a rate as specified by the Secretary for this purpose from time to time which is not less than the average rate of interest for 13-week Treasury notes.

"(D) For purposes of this paragraph and paragraph (1)(B), refunds or credits against premiums due shall be made, with respect to a policy year, not later than the third quarter of the succeeding policy year.

"(3) The provisions of this subsection do not preempt a State from requiring a higher percentage than that specified in paragraph (1)(A).

"(4) The Secretary shall submit in February of each year (beginning with 1993) a report to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on loss-ratios under medicare supplemental policies and the use of sanctions, such as a required rebate or credit or the disallowance of premium increases, for policies that fail to meet the requirements of this subsection (relating to loss-ratios). Such report shall include a list of the policies that failed to comply with such loss-ratio requirements or other requirements of this section.

"(5)(A) The Comptroller General shall periodically, not less often than once every 3 years, perform audits with respect to the compliance of medicare supplemental policies with the loss ratio requirements of this subsection and shall report the results of such audits to the State involved and to the Secretary.

"(B) The Secretary may independently perform such compliance audits.

"(6)(A) A person who issues a policy in violation of the loss ratio requirements of this subsection is subject to a civil money penalty of not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(B) Each issuer of a policy subject to the requirements of paragraph (1)(B) shall be liable to policyholders for credits required under such paragraph."

(b) ASSURING ACCESS TO LOSS RATIO INFORMATION.—Section 1882(b)(1)(C) (42 U.S.C. 1395ss(b)(1)(C)) is amended by striking the semicolon at the end and inserting a comma and the following:

"and that a copy of each such policy, the most recent premium for each such policy, and a listing of the ratio of benefits provided to premiums collected for the most recent 3-year period for each such policy issued or sold in the State is maintained and made available to interested persons;"

(c) **IMPLEMENTATION OF PROCESS TO APPROVE PREMIUM INCREASES.**—Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)) is further amended—

(1) by striking "and" at the end of subparagraph (E);

(2) by adding "and" at the end of subparagraph (F);

(3) by adding at the end thereof the following new subparagraph:

"(G) provides for a process for approving or disapproving proposed premium increases with respect to such policies, and establishes a policy for the holding of public hearings prior to approval of a premium increase,"

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to policies sold or issued more than 1 year after the date of the enactment of this Act.

SEC. 4356. CLARIFICATION OF TREATMENT OF PLANS OFFERED BY HEALTH MAINTENANCE ORGANIZATIONS.

(a) **IN GENERAL.**—The first sentence of section 1882(g)(1) is amended by inserting before the period at the end the following: "and does not include a policy or plan of a health maintenance organization or other direct service organization which offers benefits under this title, including such services under a contract under under section 1876 or an agreement under section 1833".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 4357. PRE-EXISTING CONDITION LIMITATIONS AND LIMITATION ON MEDICAL UNDERWRITING.

(a) **IN GENERAL.**—Section 1882 is amended—

(1) in subsection (c), in the matter before paragraph (1), by inserting "or the requirement described in subsection (s)" after "paragraph (3)", and

(2) by adding at the end the following new subsection:

"(s)(1) If a medicare supplemental policy replaces another medicare supplemental policy, the issuer of the replacing policy shall waive any time periods applicable to preexisting conditions, waiting period, elimination periods and probationary periods in the new medicare supplemental policy for similar benefits to the extent such time was spent under the original policy.

"(2)(A) The issuer of a medicare supplemental policy may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition for which an application is submitted during the 6 month period beginning with the first month in which the individual (who is 65 years of age or older) first is enrolled for benefits under part B.

"(B) Subject to subparagraph (C), subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for

which the policyholder received treatment or was otherwise diagnosed during the 6 months before it became effective.

"(C) If a medicare supplemental policy or certificate replaces another such policy or certificate which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new policy or certificate for similar benefits.

"(3) Any issuer of a medicare supplemental policy that fails to meet the requirements of paragraphs (1) and (2) is subject to a civil money penalty of not to exceed \$5,000 for each such failure. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a)."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

SEC. 4358. MEDICARE SELECT POLICIES.

(a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following:

"(1) If a policy meets the NAIC Model Standards and otherwise complies with the requirements of this section except that benefits under the policy are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy shall nevertheless be treated as meeting those standards if—

"(A) full benefits are provided for items and services furnished through a network of entities which have entered into contracts with the issuer of the policy;

"(B) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through the network;

"(C) the network offers sufficient access;

"(D) the issuer of the policy has arrangements for an ongoing quality assurance program for items and services furnished through the network;

"(E)(i) the issuer of the policy provides to each enrollee at the time of enrollment an explanation of (I) the restrictions on payment under the policy for services furnished other than by or through the network, (II) out of area coverage under the policy, (III) the policy's coverage of emergency services and urgently needed care, and (IV) the availability of a policy through the entity that meets the NAIC standards without reference to this subsection and the premium charged for such policy, and

"(ii) each enrollee prior to enrollment acknowledges receipt of the explanation provided under clause (i); and

"(F) the issuer of the policy makes available to individuals, in addition to the policy described in this subsection, any policy (otherwise offered by the issuer to individuals in the State) that meets the NAIC standards and other requirements of this section without reference to this subsection.

"(2) If the Secretary determines that an issuer of a policy approved under paragraph (1)—

"(A) fails substantially to provide medically necessary items and services to enrollees seeking such items and services through the issuer's network, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

"(B) imposes premiums on enrollees in excess of the premiums approved by the State,

"(C) acts to expel an enrollee for reasons other than nonpayment of premiums, or

"(D) does not provide the explanation required under paragraph (1)(E)(i) or does not obtain the acknowledgment required under paragraph (1)(E)(ii),

is subject to a civil money penalty in an amount not to exceed \$25,000 for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(3) The Secretary may enter into a contract with an entity whose policy has been certified under paragraph (1) or has been approved by a State under subsection (b)(1)(H) to determine whether items and services (furnished to individuals entitled to benefits under this title and under that policy) are not allowable under section 1862(a)(1). Payments to the entity shall be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with carriers and fiscal intermediaries and other factors that the Secretary finds appropriate. Paragraph (1), the first sentence of paragraph (2)(A), paragraph (2)(B), paragraph (3)(C), paragraph (3)(D), and paragraph (3)(E) of section 1842(b) shall apply to the entity."

(b) CONFORMING AMENDMENTS.—(1) Section 1882(c)(1) (42 U.S.C. 1395ss(c)(1)) is amended by inserting "(except as otherwise provided by subsection (t))" before the semicolon.

(2) Section 1882(b)(1) (42 U.S.C. 1395ss(b)(1)), as previously amended, is amended—

(A) in subparagraph (A), by inserting ", except as otherwise provided by subparagraph (H)" before the semicolon;

(B) by striking "and" at the end of subparagraph (F);

(C) by inserting "and" at the end of subparagraph (G); and

(D) by adding after subparagraph (G) the following:

"(H) in the case of a policy that meets the standards under subparagraph (A) except that benefits under the policy are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), provides for the application of requirements equal to or more stringent than the requirements under subsection (t)."

(3) The first sentence of section 1154(a)(4)(B) (42 U.S.C. 1320c-3(a)(4)(B)) is amended by inserting "(or subject to review under section 1882(t))" after "section 1876".

(c) EFFECTIVE DATE.—The amendments made by this section shall only apply in 15 States (as determined by the Secretary of Health

and Human Services) and only during the 3-year period beginning with 1992.

(d) *EVALUATION.*—The Secretary of Health and Human Services shall conduct an evaluation of the amendments made by this section and shall report to Congress on such evaluation by not later than January 1, 1995.

SEC. 4359. HEALTH INSURANCE ADVISORY SERVICE FOR MEDICARE BENEFICIARIES.

(a) *IN GENERAL.*—The Secretary of Health and Human Services shall establish a health insurance advisory service program (in this section referred to as the “beneficiary assistance program”) to assist medicare-eligible individuals with the receipt of services under the medicare and medicaid programs and other health insurance programs.

(b) *OUTREACH ELEMENTS.*—The beneficiary assistance program shall provide assistance—

(1) through operation using local Federal offices that provide information on the medicare program,

(2) using community outreach programs, and

(3) using a toll-free telephone information service.

(c) *ASSISTANCE PROVIDED.*—The beneficiary assistance program shall provide for information, counseling, and assistance for medicare-eligible individuals with respect to at least the following:

(1) With respect to the medicare program—

(A) eligibility,

(B) benefits (both covered and not covered),

(C) the process of payment for services,

(D) rights and process for appeals of determinations,

(E) other medicare-related entities (such as peer review organizations, fiscal intermediaries, and carriers), and

(F) recent legislative and administrative changes in the medicare program.

(2) With respect to the medicaid program—

(A) eligibility, benefits, and the application process,

(B) linkages between the medicaid and medicare programs, and

(C) referral to appropriate State and local agencies involved in the medicaid program.

(3) With respect to medicare supplemental policies—

(A) the program under section 1882 of the Social Security Act and standards required under such program,

(B) how to make informed decisions on whether to purchase such policies and on what criteria to use in evaluating different policies,

(C) appropriate Federal, State, and private agencies that provide information and assistance in obtaining benefits under such policies, and

(D) other issues deemed appropriate by the Secretary.

The beneficiary assistance program also shall provide such other services as the Secretary deems appropriate to increase beneficiary understanding of, and confidence in, the medicare program and to improve the relationship between beneficiaries and the program.

(d) *EDUCATIONAL MATERIAL.*—The Secretary, through the Administrator of the Health Care Financing Administration, shall develop appropriate educational materials and other appropriate techniques to assist employees in carrying out this section.

(e) *NOTICE TO BENEFICIARIES.*—The Secretary shall take such steps as are necessary to assure that medicare-eligible beneficiaries and the general public are made aware of the beneficiary assistance program.

(f) *REPORT.*—The Secretary shall include, in an annual report transmitted to the Congress, a report on the beneficiary assistance program and on other health insurance informational and counseling services made available to medicare-eligible individuals. The Secretary shall include in the report recommendations for such changes as may be desirable to improve the relationship between the medicare program and medicare-eligible individuals.

SEC. 4360. HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.

(a) *GRANTS.*—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall make grants to States, with approved State regulatory programs under section 1882 of the Social Security Act, that submit applications to the Secretary that meet the requirements of this section for the purpose of providing information, counseling, and assistance relating to the procurement of adequate and appropriate health insurance coverage to individuals who are eligible to receive benefits under title XVIII of the Social Security Act (in this section referred to as "eligible individuals"). The Secretary shall prescribe regulations to establish a minimum level of funding for a grant issued under this section.

(b) *GRANT APPLICATIONS.*—

(1) In submitting an application under this section, a State may consolidate and coordinate an application that consists of parts prepared by more than one agency or department of such State.

(2) As part of an application for a grant under this section, a State shall submit a plan for a State-wide health insurance information, counseling, and assistance program. Such program shall—

(A) establish or improve upon a health insurance information, counseling, and assistance program that provides counseling and assistance to eligible individuals in need of health insurance information, including—

(i) information that may assist individuals in obtaining benefits and filing claims under titles XVIII and XIX of the Social Security Act;

(ii) policy comparison information for medicare supplemental policies (as described in section 1882(g)(1) of the Social Security Act and information that may assist individuals in filing claims under such medicare supplemental policies;

(iii) information regarding long-term care insurance; and

(iv) information regarding other types of health insurance benefits that the Secretary determines to be appropriate;

(B) in conjunction with the health insurance information, counseling, and assistance program described in subparagraph (A), establish a system of referral to appropriate Federal or State departments or agencies for assistance with problems related to health insurance coverage (including legal problems), as determined by the Secretary;

(C) provide for a sufficient number of staff positions (including volunteer positions) necessary to provide the services of the health insurance information, counseling, and assistance program;

(D) provide assurances that staff members (including volunteer staff members) of the health insurance information, counseling, and assistance program have no conflict of interest in providing the services described in subparagraph (A);

(E) provide for the collection and dissemination of timely and accurate health care information to staff members;

(F) provide for training programs for staff members (including volunteer staff members);

(G) provide for the coordination of the exchange of health insurance information between the staff of departments and agencies of the State government and the staff of the health insurance information, counseling, and assistance program;

(H) make recommendations concerning consumer issues and complaints related to the provision of health care to agencies and departments of the State government and the Federal Government responsible for providing or regulating health insurance;

(I) establish an outreach program to provide the health insurance information and counseling described in subparagraph (A) and the assistance described in subparagraph (B) to eligible individuals; and

(J) demonstrate, to the satisfaction of the Secretary, an ability to provide the counseling and assistance required under this section.

(c) SPECIAL GRANTS.—

(1) A State that is conducting a health insurance information, counseling, and assistance program that is substantially similar to a program described in subsection (b)(2) shall, as a requirement for eligibility for a grant under this section, demonstrate, to the satisfaction of the Secretary, that such State shall maintain the activities of such program at least at the level that such activities were conducted immediately preceding the date of the issuance of any grant during the period of time covered by such grant under this section and that such activities will continue to be maintained at such level.

(2) If the Secretary determines that the existing health insurance information, counseling, and assistance program is substantially similar to a program described in subsection (b)(2), the Secretary may waive some or all of the requirements de-

scribed in such subsection and issue a grant to the State for the purpose of increasing the number of services offered by the health insurance information, counseling, and assistance program, experimenting with new methods of outreach in conducting such program, or expanding such program to geographic areas of the State not previously served by the program.

(d) **CRITERIA FOR ISSUING GRANTS.**—In issuing a grant under this section, the Secretary shall consider—

(1) the commitment of the State to carrying out the health insurance information, counseling, and assistance program described in subsection (b)(2), including the level of cooperation demonstrated—

(A) by the office of the chief insurance regulator of the State, or the equivalent State entity;

(B) other officials of the State responsible for overseeing insurance plans issued by nonprofit hospital and medical service associations; and

(C) departments and agencies of such State responsible for—

(i) administering funds under title XIX of the Social Security Act, and

(ii) administering funds appropriated under the Older Americans Act;

(2) the population of eligible individuals in such State as a percentage of the population of such State; and

(3) in order to ensure the needs of rural areas in such State, the relative costs and special problems associated with addressing the special problems of providing health care information, counseling, and assistance to the rural areas of such State.

(e) **ANNUAL STATE REPORT.**—A State that receives a grant under subsection (c) or (d) shall, not later than 180 days after receiving such grant, and annually thereafter, issue an annual report to the Secretary that includes information concerning—

(1) the number of individuals served by the State-wide health insurance information, counseling and assistance program of such State;

(2) an estimate of the amount of funds saved by the State, and by eligible individuals in the State, in the implementation of such program; and

(3) the problems that eligible individuals in such State encounter in procuring adequate and appropriate health care coverage.

(f) **REPORT TO CONGRESS.**—Not later than 180 days after the date of the enactment of this section, and annually thereafter, the Secretary shall issue a report to the Committee on Finance of the Senate, the Special Committee on Aging of the Senate, the Committee on Ways and Means of the House of Representatives, the Committee on Energy and Commerce of the House of Representatives, and the Select Committee on Aging of the House of Representatives that—

(1) summarizes the allocation of funds authorized for grants under this section and the expenditure of such funds;

(2) summarizes the scope and content of training conferences convened under this section;

(3) outlines the problems that eligible individuals encounter in procuring adequate and appropriate health care coverage;

(4) makes recommendations that the Secretary determines to be appropriate to address the problems described in paragraph (3); and

(5) in the case of the report issued 2 years after the date of enactment of this section, evaluates the effectiveness of counseling programs established under this program, and makes recommendations regarding continued authorization of funds for these purposes.

(f) **AUTHORIZATION OF APPROPRIATIONS FOR GRANTS.**—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, \$10,000,000 for each of fiscal years 1991, 1992, and 1993, to fund the grant programs described in this section.

SEC. 4361. MEDICARE AND MEDIGAP INFORMATION BY TELEPHONE.

(a) **IN GENERAL.**—Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1888 the following:

“MEDICARE AND MEDIGAP INFORMATION BY TELEPHONE

“SEC. 1889. The Secretary shall provide information via a toll-free telephone number on the programs under this title and on medicare supplemental policies as defined in section 1882(g)(1) (including the relationship of State programs under title XIX to such policies).”.

(b) **DEMONSTRATION PROJECTS.**—The Secretary of Health and Human Services is authorized to conduct demonstration projects in up to 5 States for the purpose of establishing statewide toll-free telephone numbers for providing information on medicare benefits, medicare supplemental policies available in the State, and benefits under the State medicaid program.

Subtitle B—Medicaid

PART 1—REDUCTION IN SPENDING

Sec. 4401. Reimbursement for prescribed drugs.

Sec. 4402. Requiring medicaid payment of premiums and cost-sharing for enrollment under group health plans where cost-effective.

PART 2—PROTECTION OF LOW-INCOME MEDICARE BENEFICIARIES

Sec. 4501. Phased-in extension of medicaid payments for medicare premiums for certain individuals with income below 120 percent of the official poverty line.

PART 3—IMPROVEMENTS IN CHILD HEALTH

Sec. 4601. Medicaid child health provisions.

Sec. 4602. Mandatory use of outreach locations other than welfare offices.

Sec. 4603. Mandatory continuation of benefits throughout pregnancy or first year of life.

Sec. 4604. Adjustment in payment for hospital services furnished to low-income children under the age of 6 years.

Sec. 4605. Presumptive eligibility.

Sec. 4606. Role in paternity determinations.

Sec. 4607. Report and transition on errors in eligibility determinations.

PART 4—MISCELLANEOUS

SUBPART A—PAYMENTS

- Sec. 4701. State medicaid matching payments through voluntary contributions and State taxes.
- Sec. 4702. Disproportionate share hospitals: counting of inpatient days.
- Sec. 4703. Disproportionate share hospitals: alternative State payment adjustments and systems.
- Sec. 4704. Federally-qualified health centers.
- Sec. 4705. Hospice payments.
- Sec. 4706. Limitation on disallowances or deferral of Federal financial participation for certain inpatient psychiatric hospital services for individuals under age 21.
- Sec. 4707. Treatment of interest on Indiana disallowance.
- Sec. 4708. Billing for services of substitute physician.

SUBPART B—ELIGIBILITY AND COVERAGE

- Sec. 4711. Home and community-based care as optional service.
- Sec. 4712. Community supported living arrangements services.
- Sec. 4713. Providing Federal medical assistance for payments for premiums for "COBRA" continuation coverage where cost effective.
- Sec. 4714. Provisions relating to spousal impoverishment.
- Sec. 4715. Disregarding German reparation payments from post-eligibility treatment of income under the medicaid program.
- Sec. 4716. Amendments relating to medicaid transition provision.
- Sec. 4717. Clarifying effect of hospice election.
- Sec. 4718. Medically needy income levels for certain 1-member families.
- Sec. 4719. Codification of coverage of rehabilitation services.
- Sec. 4720. Personal care services for Minnesota.
- Sec. 4721. Medicaid coverage of personal care services outside the home.
- Sec. 4722. Medicaid coverage of alcoholism and drug dependency treatment services.
- Sec. 4723. Medicaid spenddown option.
- Sec. 4424. Optional State medicaid disability determinations independent of the Social Security Administration.

SUBPART C—HEALTH MAINTENANCE ORGANIZATIONS

- Sec. 4731. Regulation of incentive payments to physicians.
- Sec. 4732. Special rules.
- Sec. 4733. Extension and expansion of Minnesota prepaid medicaid demonstration project.
- Sec. 4734. Treatment of certain county-operated health insuring organizations.

SUBPART D—DEMONSTRATION PROJECTS AND HOME AND COMMUNITY-BASED WAIVERS

- Sec. 4741. Home and community-based waivers.
- Sec. 4742. Timely payment under waivers of freedom of choice of hospital services.
- Sec. 4744. Provisions relating to frail elderly demonstration project waivers.
- Sec. 4745. Demonstration projects to study the effect of allowing States to extend medicaid coverage to certain low-income families not otherwise qualified to receive medicaid benefits.
- Sec. 4746. Medicaid respite demonstration project extended.
- Sec. 4747. Demonstration project to provide medicaid coverage for HIV-positive individuals.

SUBPART E—MISCELLANEOUS

- Sec. 4751. Requirements for advanced directives under State plans for medical assistance.
- Sec. 4752. Improvement in quality of physician services.
- Sec. 4753. Clarification of authority of Inspector General.
- Sec. 4754. Notice to State medical boards when adverse actions taken.
- Sec. 4755. Miscellaneous provisions.

PART 5—PROVISIONS RELATING TO NURSING HOME REFORM

- Sec. 4801. Technical corrections relating to nursing home reform.

PART 1—REDUCTIONS IN SPENDING

SEC. 4401. REIMBURSEMENT FOR PRESCRIBED DRUGS.

(a) IN GENERAL.—

(1) **DENIAL OF FEDERAL FINANCIAL PARTICIPATION UNLESS REBATE AGREEMENTS AND DRUG USE REVIEW IN EFFECT.**—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking the period at the end of paragraph (9) and inserting “; or”, and

(B) by inserting after paragraph (9) the following new paragraph:

“(10) with respect to covered outpatient drugs of a manufacturer dispensed in any State unless, (A) except as provided in section 1927(a)(3), the manufacturer complies with the rebate requirements of section 1927(a) with respect to the drugs so dispensed in all States, and (B) effective January 1, 1993, the State provides for drug use review in accordance with section 1927(g).”.

(2) **PROHIBITING STATE PLAN DRUG ACCESS LIMITATIONS FOR DRUGS COVERED UNDER A REBATE AGREEMENT.**—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(A) by striking “and” at the end of paragraph (52),

(B) by striking the period at the end of paragraph (53) and inserting “; and”, and

(C) by inserting after paragraph (53) the following new paragraph:

“(54)(A) provide that, any formulary or similar restriction (except as provided in section 1927(d)) on the coverage of covered outpatient drugs under the plan shall permit the coverage of covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under section 1927(a), which are prescribed for a medically accepted indication (as defined in subsection 1927(k)(6)), and

“(B) comply with the reporting requirements of section 1927(b)(2)(A) and the requirements of subsections (d) and (g) of section 1927.”.

(3) **REBATE AGREEMENTS FOR COVERED OUTPATIENT DRUGS, DRUG USE REVIEW, AND RELATED PROVISIONS.**—Title XIX of the Social Security Act is amended by redesignating section 1927 as section 1928 and by inserting after section 1926 the following new section:

“PAYMENT FOR COVERED OUTPATIENT DRUGS

“SEC. 1927. (a) REQUIREMENT FOR REBATE AGREEMENT.—

“(1) **IN GENERAL.**—In order for payment to be available under section 1903(a) for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b) with the Secretary, on behalf of States (except that, the Secretary may authorize a State to enter directly into agreements with a manufacturer). Any agreement between a State and a manufacturer prior to April 1, 1991, shall be deemed to have been entered into on January 1, 1991, and payment to such manufacturer shall be retro-

actively calculated as if the agreement between the manufacturer and the State had been entered into on January 1, 1991. If a manufacturer has not entered into such an agreement before March 1, 1991, such an agreement, subsequently entered into, shall not be effective until the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.

"(2) **EFFECTIVE DATE.**—Paragraph (1) shall first apply to drugs dispensed under this title on or after January 1, 1991.

"(3) **AUTHORIZING PAYMENT FOR DRUGS NOT COVERED UNDER REBATE AGREEMENTS.**—Paragraph (1), and section 1903(i)(10)(A), shall not apply to the dispensing of a single source drug or innovator multiple source drug if (A)(i) the State has made a determination that the availability of the drug is essential to the health of beneficiaries under the State plan for medical assistance; (ii) such drug has been given a rating of 1-A by the Food and Drug Administration; and (iii)(I) the physician has obtained approval for use of the drug in advance of its dispensing in accordance with a prior authorization program described in subsection (d), or (II) the Secretary has reviewed and approved the State's determination under subparagraph (A); or (B) the Secretary determines that in the first calendar quarter of 1991, there were extenuating circumstances.

"(4) **EFFECT ON EXISTING AGREEMENTS.**—In the case of a rebate agreement in effect between a State and a manufacturer on the date of the enactment of this section, such agreement, for the initial agreement period specified therein, shall be considered to be a rebate agreement in compliance with this section with respect to that State, if the State agrees to report to the Secretary any rebates paid pursuant to the agreement and such agreement provides for a minimum aggregate rebate of 10 percent of the State's total expenditures under the State plan for coverage of the manufacturer's drugs under this title. If, after the initial agreement period, the State establishes to the satisfaction of the Secretary that an agreement in effect on the date of the enactment of this section provides for rebates that are at least as large as the rebates otherwise required under this section, and the State agrees to report any rebates under the agreement to the Secretary, the agreement shall be considered to be a rebate agreement in compliance with the section for the renewal periods of such agreement.

"(b) **TERMS OF REBATE AGREEMENT.**—

"(1) **PERIODIC REBATES.**—

"(A) **IN GENERAL.**—A rebate agreement under this subsection shall require the manufacturer to provide, to each State plan approved under this title, a rebate each calendar quarter (or periodically in accordance with a schedule specified by the Secretary) in an amount specified in subsection (c) for covered outpatient drugs of the manufacturer dispensed under the plan during the quarter (or such other period as the Secretary may specify). Such rebate shall be paid by the manufacturer not later than 30 days after the date of receipt of the information described in paragraph (2) for the period involved.

"(B) **OFFSET AGAINST MEDICAL ASSISTANCE.**—Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) or an agreement described in subsection (a)(4)) in any quarter shall be considered to be a reduction in the amount expended under the State plan in the quarter for medical assistance for purposes of section 1903(a)(1).

"(2) **STATE PROVISION OF INFORMATION.**—

"(A) **STATE RESPONSIBILITY.**—Each State agency under this title shall report to each manufacturer not later than 60 days after the end of each calendar quarter and in a form consistent with a standard reporting format established by the Secretary, information on the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter, and shall promptly transmit a copy of such report to the Secretary.

"(B) **AUDITS.**—A manufacturer may audit the information provided (or required to be provided) under subparagraph (A). Adjustments to rebates shall be made to the extent that information indicates that utilization was greater or less than the amount previously specified.

"(3) **MANUFACTURER PROVISION OF PRICE INFORMATION.**—

"(A) **IN GENERAL.**—Each manufacturer with an agreement in effect under this section shall report to the Secretary—

"(i) not later than 30 days after the last day of each quarter (beginning on or after January 1, 1991), on the average manufacturer price (as defined in subsection (k)(1)) and, (for single source drugs and innovator multiple source drugs), the manufacturer's best price (as defined in subsection (c)(2)(B)) for covered outpatient drugs for the quarter, and

"(ii) not later than 30 days after the date of entering into an agreement under this section on the average manufacturer price (as defined in subsection (k)(1)) as of October 1, 1990 for each of the manufacturer's covered outpatient drugs.

"(B) **VERIFICATION SURVEYS OF AVERAGE MANUFACTURER PRICE.**—The Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed \$100,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information about charges or prices by the Secretary in connection with a survey under this subparagraph or knowingly provides false information. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or additional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(C) **PENALTIES.**—

“(i) **FAILURE TO PROVIDE TIMELY INFORMATION.**—In the case of a manufacturer with an agreement under this section that fails to provide information required under subparagraph (A) on a timely basis, the amount of the penalty shall be increased by \$10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury, and, if such information is not reported within 90 days of the deadline imposed, the agreement shall be suspended for services furnished after the end of such 90-day period and until the date such information is reported (but in no case shall such suspension be for a period of less than 30 days).

“(ii) **FALSE INFORMATION.**—Any manufacturer with an agreement under this section that knowingly provides false information is subject to a civil money penalty in an amount not to exceed \$100,000 for each item of false information. Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(D) **CONFIDENTIALITY OF INFORMATION.**—Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph is confidential and shall not be disclosed by the Secretary or a State agency (or contractor therewith) in a form which discloses the identity of a specific manufacturer or wholesaler, prices charged for drugs by such manufacturer or wholesaler, except as the Secretary determines to be necessary to carry out this section and to permit the Comptroller General to review the information provided.

“(4) **LENGTH OF AGREEMENT.**—

“(A) **IN GENERAL.**—A rebate agreement shall be effective for an initial period of not less than 1 year and shall be automatically renewed for a period of not less than one year unless terminated under subparagraph (B).

“(B) **TERMINATION.**—

“(i) **BY THE SECRETARY.**—The Secretary may provide for termination of a rebate agreement for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

“(ii) **BY A MANUFACTURER.**—A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until such period after the date of the notice as the

Secretary may provide (but not beyond the term of the agreement).

"(iii) **EFFECTIVENESS OF TERMINATION.**—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

"(C) **DELAY BEFORE REENTRY.**—In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since the date of the termination, unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

"(c) **AMOUNT OF REBATE.**—

"(I) **BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.**—With respect to single source drugs and innovator multiple source drugs, each manufacturer shall remit a basic rebate to the State medical assistance plan. Except as otherwise provided in this subsection, the amount of the rebate to a State for a calendar quarter (or other period specified by the Secretary) with respect to each dosage form and strength of single source drugs and innovator multiple source drugs shall be equal to the product of—

"(A) the total number of units of each dosage form and strength dispensed under the plan under this title in the quarter (or other period) reported by the State under subsection (b)(2); and

"(B)(i) for quarters (or periods) beginning after December 31, 1990, and before January 1, 1993, the greater of—

"(I) the difference between the average manufacturer price (after deducting customary prompt payment discounts) and 87.5 percent of such price for the quarter (or other period), or

"(II) the difference between the average manufacturer price for a drug and the best price (as defined in paragraph (2)(B)) for such quarter (or period) for such drug (except that for calendar quarters beginning after December 31, 1990, and ending before January 1, 1992, the rebate shall not exceed 25 percent of the average manufacturer price, and for calendar quarters beginning after December 31, 1991, and ending before January 1, 1993, the rebate shall not exceed 50 percent of the average manufacturer price); and

"(ii) for quarters (or other periods) beginning after December 31, 1992, the greater of—

"(I) the difference between the average manufacturer price for a drug and 85 percent of such price, or

"(II) the difference between the average manufacturer price for a drug and the best price (as defined in paragraph (2)(B)) for such quarter (or period) for such drug.

"(C) For the purposes of this paragraph, the term 'best price' means, with respect to a single source drug or innovator multiple source drug of a manufacturer, the lowest price available from the manufacturer to any wholesaler, retailer, nonprofit

entity, or governmental entity within the United States (excluding depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government). The best price shall be inclusive of cash discounts, free goods, volume discounts, and rebates (other than rebates under this section) and shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package, and shall not take into account prices that are merely nominal in amount;

"(D) In the case of a covered outpatient drug approved for marketing after October 1, 1990, any reference in this paragraph to 'October 1, 1990' shall be a reference to the first day of the first month during which the drug was marketed.

"(2) ADDITIONAL REBATE FOR SINGLE SOURCE AND INNOVATOR MULTIPLE SOURCE DRUGS.—(A) Each manufacturer shall remit an additional rebate to the State medical assistance plan in an amount equal to:

"(i) For calendar quarters (or other periods) beginning after December 31, 1990 and ending before January 1, 1994—

"(I) the total number of each dosage form and strength of a single source or innovator multiple source drug dispensed during the calendar quarter (or other period); multiplied by

"(II)(aa) the average manufacturer price for each dosage form and strength, minus

"(bb) the average manufacturer price for each such dosage form and strength in effect on October 1, 1990, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from October 1, 1990, to the month before the beginning of the calendar quarter (or other period) involved;

"(ii) For calendar quarters (or other periods) beginning after December 31, 1993—

"(I) the total number of each dosage form and strength of a single source or innovative multiple source drug dispensed during the calendar quarter (or other period); multiplied by

"(II) the amount, if any, by which the weighted average manufacturer price for single source and innovator multiple source drugs of a manufacturer exceeds the weighted average manufacturer price for the manufacturer as of October 1, 1990, increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) from October 1, 1990, to the month before the beginning of the calendar quarter (or other period) involved.

"(B)(i) For the purposes of subparagraph (A)(ii), the term 'weighted average manufacturer price' means (with respect to a calendar quarter or other period) the ratio of—

"(I) the sum of the products (for all covered drugs of the manufacturer purchased under a State program under this title) of—

"(aa) the average manufacturer price for each such covered drug; and

"(bb) the number of units of the covered drug sold to any State program under this title during such period, to

"(II) the total number of units of all such covered drugs sold under a State program under this title in such period, except that the Secretary may exclude certain new drugs from the calculation of the weighted average if the inclusion of any such drug in such calculation has the effect of—

"(aa) reducing the rebate otherwise calculated pursuant to subparagraph (A)(ii); or

"(bb) increasing the rebate otherwise calculated pursuant to subparagraph (A)(ii) (in cases where such calculation under the conditions outlined in clause (ii).

"(ii)(I) The Secretary may exclude drugs approved by the Food and Drug Administration on or after October 1, 1990, from the calculation of weighted average manufacturer price if inclusion demonstrates through a petition, in a form and manner prescribed by the Secretary, undue hardship on such manufacturer as a result of the inclusion of such drug in such calculation).

"(II) The Secretary may promulgate guidelines to restrict the conditions under which the Secretary may consider such petitions.

"(C) For each of 8 calendar quarters beginning after December 31, 1991, the Secretary shall compare the aggregate amount of the rebates under subparagraph (A)(i) to the aggregate amount of rebates under subparagraph (A)(ii). Based on any such comparison, the Secretary may propose and utilize an alternative formula for the purpose of calculating an aggregate rebate.

"(3) REBATE FOR OTHER DRUGS.—The amount of the rebate to a State for a calendar quarter (or other period specified by the Secretary) with respect to covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of—

"(A) the applicable percentage (as described in paragraph (4) of the average manufacturer price for each dosage form and strength of such drugs (after deducting customary prompt payment discounts) for the quarter (or other period), and

"(B) the number of units of such form and dosage dispensed under the plan under this title in the quarter (or other period) reported by the State under subsection (b)(2).

"(4) For the purposes of paragraph (3), the applicable percentage is—

"(A) with respect to calendar quarters beginning after December 31, 1990, and ending before January 1, 1994, 10 percent; and

"(B) with respect to calendar quarters beginning on or after December 31, 1993, 11 percent.

"(d) LIMITATIONS ON COVERAGE OF DRUGS.—

"(1) PERMISSIBLE RESTRICTIONS.—(A) Except as provided in paragraph (6), a State may subject to prior authorization any

covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).

"(B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if—

"(i) the prescribed use is not for a medically accepted indication (as defined in (k)(6));

"(ii) the drug is contained in the list referred to in paragraph (2); or

"(iii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4).

"(2) LIST OF DRUGS SUBJECT TO RESTRICTION.—The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

"(A) Agents when used for anorexia or weight gain.

"(B) Agents when used to promote fertility.

"(C) Agents when used for cosmetic purposes or hair growth.

"(D) Agents when used for the symptomatic relief of cough and colds.

"(E) Agents when used to promote smoking cessation.

"(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

"(G) Nonprescription drugs.

"(H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

"(I) Drugs described in section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations ('DESI' drugs)).

"(J) Barbiturates.

"(K) Benzodiazepines.

"(3) UPDATE OF DRUG LISTINGS.—The Secretary shall (except with respect to new drugs approved by the FDA for the first 6 months following the date of approval of such drugs shall not be subject to being listed in paragraph (2) under the provisions of this paragraph), by regulation, periodically update the list of drugs described in paragraph (2) or classes of drugs, or their medical uses, which the Secretary has determined, based on data collected by surveillance and utilization review programs of State medical assistance programs, to be subject to clinical abuse or inappropriate use.

"(4) INNOVATOR MULTIPLE-SOURCE DRUGS.—Innovator multiple-source drugs shall be treated under applicable State and Federal law and regulation.

"(5) PRIOR AUTHORIZATION PROGRAMS.—A State plan under this title may not require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, the approval of the drug before its dispensing for any medically ac-

cepted indication (as defined in subsection (k)(6)) unless the system providing for such approval—

“(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

“(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

“(6) TREATMENT OF NEW DRUGS.—A State may not exclude for coverage, subject to prior authorization, or otherwise restrict any new biological or drug approved by the Food and Drug Administration after the date of enactment of this section, for a period of 6 months after such approval.

“(7) OTHER PERMISSIBLE RESTRICTIONS.—A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, provided such limitations are necessary to discourage waste.

Nothing in this section shall restrict the ability of a State to address individual instances of fraud or abuse in any manner authorized under the Social Security Act.

“(8) DELAYED EFFECTIVE DATE.—The provisions of paragraph (5) shall become effective with respect to drugs dispensed under this title on or after July 1, 1991.

“(e) DENIAL OF FEDERAL FINANCIAL PARTICIPATION IN CERTAIN CASES.—The Secretary shall provide that no payment shall be made to a State under section 1903(a) for an innovator multiple-source drug dispensed on or after July 1, 1991, if, under applicable State law, a less expensive noninnovator multiple source drug (other than the innovator multiple-source drug) could have been dispensed.

“(f) PHARMACY REIMBURSEMENT.—

“(1) NO REDUCTIONS IN REIMBURSEMENT LIMITS.—(A) During the period of time beginning on January 1, 1991, and ending on December 31, 1994, the Secretary may not modify by regulation the formula used to determine reimbursement limits described in the regulations under 42 CFR 447.331 through 42 CFR 447.334 (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1990) to reduce such limits for covered outpatient drugs.

(B) During the period of time described in subparagraph (A), any State that was in compliance with the regulations described in subparagraph (A) may not reduce the limits for covered outpatient drugs described in subparagraph (A) or dispensing fees for such drugs.

“(2) ESTABLISHMENT OF UPPER PAYMENT LIMITS.—HCFA shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

“(g) DRUG USE REVIEW.—

“(1) IN GENERAL.—

"(A) In order to meet the requirement of section 1903(i)(10)(B), a State shall provide, by not later than January 1, 1993, for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

"(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

"(i) compendia which shall consist of the following:

"(I) American Hospital Formulary Service Drug Information;

"(II) United States Pharmacopeia-Drug Information; and

"(III) American Medical Association Drug Evaluations; and

"(ii) the peer-reviewed medical literature.

"(C) The Secretary, under the procedures established in section 1903, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

"(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing section 1919, currently at section 483.60 of title 42, Code of Federal Regulations.

"(2) DESCRIPTION OF PROGRAM.—Each drug use review program shall meet the following requirements for covered outpatient drugs:

"(A) PROSPECTIVE DRUG REVIEW.—(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this title, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of

drug treatment, drug-allergy interactions, and clinical abuse/misuse. Each State shall use the compendia and literature referred to in paragraph (1)(B) as its source of standards for such review.

"(ii) As part of the State's prospective drug use review program under this subparagraph applicable State law shall establish standards for counseling of individuals receiving benefits under this title by pharmacists which includes at least the following:

"(I) The pharmacist must offer to discuss with each individual receiving benefits under this title or caregiver of such individual (in person, whenever practicable, or through access to a telephone service which is toll-free for long-distance calls) who presents a prescription, matters which in the exercise of the pharmacist's professional judgment (consistent with State law respecting the provision of such information), the pharmacist deems significant including the following:

"(aa) The name and description of the medication.

"(bb) The route, dosage form, dosage, route of administration, and duration of drug therapy.

"(cc) Special directions and precautions for preparation, administration and use by the patient.

"(dd) Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.

"(ee) Techniques for self-monitoring drug therapy.

"(ff) Proper storage.

"(gg) Prescription refill information.

"(hh) Action to be taken in the event of a missed dose.

"(II) A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving benefits under this title:

"(aa) Name, address, telephone number, date of birth (or age) and gender.

"(bb) Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.

"(cc) Pharmacist comments relevant to the individuals drug therapy.

Nothing in this clause shall be construed as requiring a pharmacist to provide consultation when an individual receiving benefits under this title or caregiver of such individual refuses such consultation.

“(B) **RETROSPECTIVE DRUG USE REVIEW.**—The program shall provide, through its mechanized drug claims processing and information retrieval systems (approved by the Secretary under section 1903(r)) or otherwise, for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits under this title, or associated with specific drugs or groups of drugs.

“(C) **APPLICATION OF STANDARDS.**—The program shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using the compendia and literature referred to in subsection (1)(B) as the source of standards for such assessment) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

“(D) **EDUCATIONAL PROGRAM.**—The program shall, through its State drug use review board established under paragraph (3), either directly or through contracts with accredited health care educational institutions, State medical societies or State pharmacists associations/societies or other organizations as specified by the State, and using data provided by the State drug use review board on common drug therapy problems, provide for active and ongoing educational outreach programs (including the activities described in paragraph (3)(C)(iii) of this subsection) to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices.

“(3) **STATE DRUG USE REVIEW BOARD.**—

“(A) **ESTABLISHMENT.**—Each State shall provide for the establishment of a drug use review board (hereinafter referred to as the ‘DUR Board’) either directly or through a contract with a private organization.

“(B) **MEMBERSHIP.**—The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

“(i) The clinically appropriate prescribing of covered outpatient drugs.

“(ii) The clinically appropriate dispensing and monitoring of covered outpatient drugs.

“(iii) Drug use review, evaluation, and intervention.

“(iv) Medical quality assurance.

The membership of the DUR Board shall be made up of at least $\frac{1}{3}$ but no more than 51 percent licensed and actively practicing physicians and at least $\frac{1}{3}$ * * * licensed and actively practicing pharmacists.

"(C) ACTIVITIES.—The activities of the DUR Board shall include but not be limited to the following:

"(i) Retrospective DUR as defined in section (2)(B).

"(ii) Application of standards as defined in section (2)(C).

"(iii) Ongoing interventions for physicians and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews performed under this subsection. Intervention programs shall include, in appropriate instances, at least:

"(I) information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;

"(II) written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;

"(III) use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and

"(IV) intensified review or monitoring of selected prescribers or dispensers.

The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

"(D) ANNUAL REPORT.—Each State shall require the DUR Board to prepare a report on an annual basis. The State shall submit a report on an annual basis to the Secretary which shall include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The Secretary shall utilize such report in evaluating the effectiveness of each State's drug use review program.

"(h) ELECTRONIC CLAIMS MANAGEMENT.—

"(1) IN GENERAL.—In accordance with chapter 35 of title 44, United States Code (relating to coordination of Federal information policy), the Secretary shall encourage each State agency to establish, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, ad-

judication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

"(2) **ENCOURAGEMENT.**—In order to carry out paragraph (1)—

"(A) for calendar quarters during fiscal years 1991 and 1992, expenditures under the State plan attributable to development of a system described in paragraph (1) shall receive Federal financial participation under section 1903(a)(3)(A)(i) (at a matching rate of 90 percent) if the State acquires, through applicable competitive procurement process in the State, the most cost-effective telecommunications network and automatic data processing services and equipment; and

"(B) the Secretary may permit, in the procurement described in subparagraph (A) in the application of part 433 of title 42, Code of Federal Regulations, and parts 95, 205, and 307 of title 45, Code of Federal Regulations, the substitution of the State's request for proposal in competitive procurement for advance planning and implementation documents otherwise required.

"(i) **ANNUAL REPORT.**—

"(1) **IN GENERAL.**—Not later than May 1 of each year the Secretary shall transmit to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives a report on the operation of this section in the preceding fiscal year.

"(2) **DETAILS.**—Each report shall include information on—

"(A) ingredient costs paid under this title for single source drugs, multiple source drugs, and nonprescription covered outpatient drugs;

"(B) the total value of rebates received and number of manufacturers providing such rebates;

"(C) how the size of such rebates compare with the size or rebates offered to other purchasers of covered outpatient drugs;

"(D) the effect of inflation on the value of rebates required under this section;

"(E) trends in prices paid under this title for covered outpatient drugs; and

"(F) Federal and State administrative costs associated with compliance with the provisions of this title.

"(j) **EXEMPTION OF ORGANIZED HEALTH CARE SETTINGS.**—(1) Covered outpatient drugs dispensed by *** Health Maintenance Organizations, including those organizations that contract under section 1903(m), are not subject to the requirements of this section.

"(2) The State plan shall provide that a hospital (providing medical assistance under such plan) that dispenses covered outpatient drugs using drug formulary systems, and bills the plan no more than the hospital's purchasing costs for covered outpatient drugs (as determined under the State plan) shall not be subject to the requirements of this section.

"(3) Nothing in this subsection shall be construed as providing that amounts for covered outpatient drugs paid by the institutions

described in this subsection should not be taken into account for purposes of determining the best price as described in subsection (c).

“(k) DEFINITIONS.—In this section—

“(1) AVERAGE MANUFACTURER PRICE.—The term ‘average manufacturer price’ means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade.

“(2) COVERED OUTPATIENT DRUG.—Subject to the exceptions in paragraph (3), the term ‘covered outpatient drug’ means—

“(A) of those drugs which are treated as prescribed drugs for purposes of section 1905(a)(12), a drug which may be dispensed only upon prescription (except as provided in paragraph (5)), and—

“(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

“(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a ‘new drug’ (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

“(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

“(B) a biological product, other than a vaccine which—

“(i) may only be dispensed upon prescription,

“(ii) is licensed under section 351 of the Public Health Service Act, and

“(iii) is produced at an establishment licensed under such section to produce such product; and

“(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

"(3) *LIMITING DEFINITION.*—The term 'covered outpatient drug' does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug):

"(A) Inpatient hospital services.

"(B) Hospice services.

"(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

"(D) Physicians' services.

"(E) Outpatient hospital services * * * emergency room visits.

"(F) Nursing facility services.

"(G) Other laboratory and x-ray services.

"(H) Renal dialysis.

Such term also does not include any such drug or product which is used for a medical indication which is not a medically accepted indication.

"(4) *NONPRESCRIPTION DRUGS.*—If a State plan for medical assistance under this title includes coverage of prescribed drugs as described in section 1905(a)(12) and permits coverage of drugs which may be sold without a prescription (commonly referred to as 'over-the-counter' drugs), if they are prescribed by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

"(5) *MANUFACTURER.*—The term 'manufacturer' means any entity which is engaged in—

"(A) the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or

"(B) in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products.

Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

"(6) *MEDICALLY ACCEPTED INDICATION.*—The term 'medically accepted indication' means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, which appears in peer-reviewed medical literature or which is accepted by one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, and the United States Pharmacopeia-Drug Information.

"(7) *MULTIPLE SOURCE DRUG; INNOVATOR MULTIPLE SOURCE DRUG; NONINNOVATOR MULTIPLE SOURCE DRUG; SINGLE SOURCE DRUG.*—

"(A) *DEFINED.*—

"(i) *MULTIPLE SOURCE DRUG.*—The term 'multiple source drug' means, with respect to a calendar quarter, a covered outpatient drug (not including any drug de-

scribed in paragraph (5)) for which there are 2 or more drug products which—

“(I) are rated as therapeutically equivalent (under the Food and Drug Administration’s most recent publication of ‘Approved Drug Products with Therapeutic Equivalence Evaluations’),

“(II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and

“(III) are sold or marketed in the State during the period.

“(ii) **INNOVATOR MULTIPLE SOURCE DRUG.**—The term ‘innovator multiple source drug’ means a multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

“(iii) **NONINNOVATOR MULTIPLE SOURCE DRUG.**—The term ‘noninnovator multiple source drug’ means a multiple source drug that is not an innovator multiple source drug.

“(iv) **SINGLE SOURCE DRUG.**—The term ‘single source drug’ means a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

“(B) **EXCEPTION.**—Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

“(C) **DEFINITIONS.**—For purposes of this paragraph—

“(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity;

“(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence; and

“(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.

“(8) **STATE AGENCY.**—The term ‘State agency’ means the agency designated under section 1902(a)(5) to administer or su-

pervise the administration of the State plan for medical assistance.”.

(b) **FUNDING.**—

(1) **DRUG USE REVIEW PROGRAMS.**—Section 1903(a)(3) (42 U.S.C. 1936b(a)(3)) is amended—

(A) by striking “plus” at the end of subparagraph (C) and inserting “and”, and

(B) by adding at the end the following new subparagraph:

“(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1927(g); plus”.

(2) **TEMPORARY INCREASE IN FEDERAL MATCH FOR ADMINISTRATIVE COSTS.**—The per centum to be applied under section 1903(a)(7) of the Social Security Act for amounts expended during calendar quarters in fiscal year 1991 which are attributable to administrative activities necessary to carry out section 1927 (other than subsection (g)) of such Act shall be 75 percent, rather than 50 percent; after fiscal year 1991, the match shall revert back to 50 percent.

(c) **DEMONSTRATION PROJECTS.**—

(1) **PROSPECTIVE DRUG UTILIZATION REVIEW.**—

(A) The Secretary of Health and Human Services shall provide, through competitive procurement by not later than January 1, 1992, for the establishment of at least 10 statewide demonstration projects to evaluate the efficiency and cost-effectiveness of prospective drug utilization review (as a component of on-line, real-time electronic point-of-sales claims management) in fulfilling patient counseling and in reducing costs for prescription drugs.

(B) Each of such projects shall establish a central electronic repository for capturing, storing, and updating prospective drug utilization review data and for providing access to such data by participating pharmacists (and other authorized participants).

(C) Under each project, the pharmacist or other authorized participant shall assess the active drug regimens of recipients in terms of duplicate drug therapy, therapeutic overlap, allergy and cross-sensitivity reactions, drug interactions, age precautions, drug regiment compliance, prescribing limits, and other appropriate elements.

(D) Not later than January 1, 1994, the Secretary shall submit to Congress a report on the demonstration projects conducted under this paragraph.

(2) **DEMONSTRATION PROJECT ON COST-EFFECTIVENESS OF REIMBURSEMENT FOR PHARMACISTS’ COGNITIVE SERVICES.**—

(A) The Secretary of Health and Human Services shall conduct a demonstration project to evaluate the impact on quality of care and cost-effectiveness of paying pharmacists under title XIX of the Social Security Act, whether or not a drug is dispensed, for drug use review services. For this purpose, the Secretary shall provide for no fewer than 5 dem-

onstration sites in different States and the participation of a significant number of pharmacists.

(B) Not later than January 1, 1995, the Secretary shall submit a report to the Congress on the results of the demonstration project conducted under subparagraph (A).

(d) **STUDIES.**—

(1) **STUDY OF DRUG PURCHASING AND BILLING ACTIVITIES OF VARIOUS HEALTH CARE SYSTEMS.**—

(A) The Comptroller General shall conduct a study of the drug purchasing and billing practices of hospitals, other institutional facilities, and managed care plans which provide covered outpatient drugs in the medicaid program. The study shall compare the ingredient costs of drugs for medicaid prescriptions to these facilities and plans and the charges billed to medical assistance programs by these facilities and plans compared to retail pharmacies.

(B) The study conducted under this subsection shall include an assessment of—

(i) the prices paid by these institutions for covered outpatient drugs compared to prices that would be paid under this section,

(ii) the quality of outpatient drug use review provided by these institutions as compared to drug use review required under this section, and

(iii) the efficiency of mechanisms used by these institutions for billing and receiving payment for covered outpatient drugs dispensed under this title.

(C) By not later than May 1, 1991, the Comptroller General shall report to the Secretary of Health and Human Services (hereafter in this section referred to as the "Secretary"), the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives on the study conducted under subparagraph (A).

(2) **REPORT ON DRUG PRICING.**—By not later than May 1 of each year, the Comptroller General shall submit to the Secretary, the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and House of Representatives an annual report on changes in prices charged by manufacturers for prescription drugs to the Department of Veterans Affairs, other Federal programs, retail and hospital pharmacies, and other purchasing groups and managed care plans.

(3) **STUDY ON PRIOR APPROVAL PROCEDURES.**—

(A) The Secretary, acting in consultation with the Comptroller General, shall study prior approval procedures utilized by State medical assistance programs conducted under title XIX of the Social Security Act, including—

(i) the appeals provisions under such programs; and

(ii) the effects of such procedures on beneficiary and provider access to medications covered under such programs.

(B) By not later than December 31, 1991, the Secretary and the Comptroller General shall report to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives on the results of the study conducted under subparagraph (A) and shall make recommendations with respect to which procedures are appropriate or inappropriate to be utilized by State plans for medical assistance.

(4) **STUDY ON REIMBURSEMENT RATES TO PHARMACISTS.**—

(A) The Secretary shall conduct a study on (i) the adequacy of current reimbursement rates to pharmacists under each State medical assistance programs conducted under title XIX of the Social Security Act; and (ii) the extent to which reimbursement rates under such programs have an effect on beneficiary access to medications covered and pharmacy services under such programs.

(B) By not later than December 31, 1991, the Secretary shall report to the Committee on Finance of the Senate, the Committee on Energy and Commerce of the House of Representatives, and the Committees on Aging of the Senate and the House of Representatives on the results of the study conducted under subparagraph (A).

(5) **STUDY OF PAYMENTS FOR VACCINES.**—The Secretary of Health and Human Services shall undertake a study of the relationship between State medical assistance plans and Federal and State acquisition and reimbursement policies for vaccines and the accessibility of vaccinations and immunization to children provided under this title. The Secretary shall report to the Congress on the Study not later than one year after the date of the enactment of this Act.

(6) **STUDY ON APPLICATION OF DISCOUNTING OF DRUGS UNDER MEDICARE.**—The Comptroller General shall conduct a study examining methods to encourage providers of items and services under title XVIII of the Social Security Act to negotiate discounts with suppliers of prescription drugs to such providers. The Comptroller General shall submit to Congress a report on such study no later than 1 year after the date of enactment of this subsection.

SEC. 4402. REQUIRING MEDICAID PAYMENT OF PREMIUMS AND COST-SHARING FOR ENROLLMENT UNDER GROUP HEALTH PLANS WHERE COST-EFFECTIVE.

(a) **IN GENERAL.**—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(1) in section 1902(a)(25) (42 U.S.C. 1396a(a)(25))—

(A) by striking “and” at the end of subparagraph (E),

(B) by adding “and” at the end of subparagraph (F), and

(C) by adding at the end the following new subparagraph:

“(G) that the State plan shall meet the requirements of section 1906 (relating to enrollment of individuals under group health plans in certain cases);” and

(2) by inserting after section 1905 the following new section:

"ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS

"SEC. 1906. (a) For purposes of section 1902(a)(25)(G) and subject to subsection (d), each State plan—

"(1) shall implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this title in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2));

"(2) shall require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this title and subject to subsection (b)(2), notwithstanding any other provision of this title, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and

"(3) in the case of such enrollment (except as provided in subsection (c)(1)(B)), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916), and shall treat coverage under the group health plan as a third party liability (under section 1902(a)(25)).

"(b)(1) In establishing guidelines under subsection (a)(1), the Secretary shall take into account that an individual may only be eligible to enroll in group health plans at limited times and only if other individuals (not entitled to medical assistance under the plan) are also enrolled in the plan simultaneously.

"(2) If a parent of a child fails to enroll the child in a group health plan in accordance with subsection (a)(2), such failure shall not affect the child's eligibility for benefits under this title.

"(c)(1)(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

"(B) If all members of a family are not eligible for medical assistance under this title and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—

"(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account payment of all such premiums), but

"(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals.

"(2) The fact that an individual is enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1902(a)(25) provides that payment for such benefits shall first be made by such plan.

"(d)(1) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the

Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

"(2) This section, and section 1902(a)(25)(G), shall only apply to a State that is one of the 50 States or the District of Columbia.

"(e) In this section:

"(1) The term 'group health plan' has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, and includes the provision of continuation coverage by such a plan pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

"(2) The term 'cost-effective' means, as established by the Secretary, that the reduction in expenditures under this title with respect to an individual who is enrolled in a group health plan is likely to be greater than the additional expenditures for premiums and cost-sharing required under this section with respect to such enrollment."

(b) **TREATMENT OF ERRONEOUS EXCESS PAYMENTS FOR MEDICAL ASSISTANCE.**—Section 1903(u)(1)(C)(iv) (42 U.S.C. 1396b(u)(1)(C)(iv)) is amended by inserting before the period at the end the following: "or with respect to payments made in violation of section 1906".

(c) **OPTIONAL MINIMUM 6-MONTH ELIGIBILITY.**—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following new paragraph:

"(11)(A) In the case of an individual who is enrolled with a group health plan under section 1906 and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

"(B) For purposes of subparagraph (A), the term 'minimum enrollment period' means, with respect to an individual's enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual's enrollment under the plan becomes effective."

(d) **CONFORMING AMENDMENTS.**—

(1) Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (E)—

(A) by striking "and" at the end of subdivision (IX);

(B) by inserting "and" at the end of subdivision (X); and

(C) by adding at the end the following new subdivision:

"(XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of

the same amount, duration, and scope of such private coverage to any other individuals;”.

(2) Section 1905(a) (42 U.S.C. 1396d(a)) is amended by adding at the end the following: “The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof.”.

(3) Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by striking “(including expenditures for” and all that follows through “or the cost thereof)”.

(e) **EFFECTIVE DATE.**—(1) The amendments made by this section apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

PART 2—PROTECTION OF LOW-INCOME MEDICARE BENEFICIARIES

SEC. 4501. PHASED-IN EXTENSION OF MEDICAID PAYMENTS FOR MEDICARE PREMIUMS FOR CERTAIN INDIVIDUALS WITH INCOME BELOW 120 PERCENT OF THE OFFICIAL POVERTY LINE.

(a) **1-YEAR ACCELERATION OF BUY-IN OF PREMIUMS AND COST SHARING FOR QUALIFIED MEDICARE BENEFICIARIES UP TO 100 PERCENT OF POVERTY LINE.**—Section 1905(p)(2) (42 U.S.C. 1396d(p)(2)) is further amended—

(1) in subparagraph (B)—

(A) by adding “and” at the end of clause (ii);

(B) in clause (iii), by striking “95 percent, and” and inserting “100 percent.”; and

(C) by striking clause (iv); and

(2) in subparagraph (C)—

(A) in clause (iii), by striking “90” and inserting “95”;

(B) by adding “and” at the end of clause (iii);

(C) in clause (iv), by striking “95 percent, and” and inserting “100 percent.”; and

(D) by striking clause (v).

(b) **ENTITLEMENT.**—Section 1902(a)(10)(E) (42 U.S.C. 1395b(a)(10)(E)(ii)) is amended—

(1) by striking “, and” at the end of clause (i) and inserting a semicolon;

(2) by adding “and” at the end of clause (ii); and

(3) by adding at the end the following new clause:

“(iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) subject to section 1905(p)(4), for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved;”

(c) **APPLICATION IN CERTAIN STATES AND TERRITORIES.**—Section 1905(p)(4) (42 U.S.C. 1396d(p)(4)) is amended—

(1) in subparagraph (B), by inserting “or 1902(a)(10)(E)(iii)” after “subparagraph (B)”, and

(2) by adding at the end the following:

“In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirement of section 1902(a)(10)(E) in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.”

(d) **CONFORMING AMENDMENT.**—Section 1843(h) (42 U.S.C. 1395v(h)) is amended by adding at the end the following new paragraph:

“(3) In this subsection, the term ‘qualified medicare beneficiary’ also includes an individual described in section 1902(a)(10)(E)(iii).”

(e) **DELAY IN COUNTING SOCIAL SECURITY COLA INCREASES UNTIL NEW POVERTY GUIDELINES PUBLISHED.**—

(1) **IN GENERAL.**—Section 1905(p) is amended—

(A) in paragraph (1)(B), by inserting “, except as provided in paragraph (2)(D)” after “supplementary social security income program”, and

(B) by adding at the end of paragraph (2) the following new subparagraph:

“(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under title II for a transition month (as defined in clause (ii)) in a year, such

income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year.

"(ii) For purposes of clause (i), the term 'transition month' means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published."

(2) **CONFORMING AMENDMENTS.**—Section 1902(m) (42 U.S.C. 1396a(m)) is amended—

(A) in paragraph (1)(B), by inserting ", except as provided in paragraph (2)(C)" after "supplemental security income program", and

(B) by adding at the end of paragraph (2) the following new subparagraph:

"(C) The provisions of section 1905(p)(2)(D) shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1905(p)."

(f) **EFFECTIVE DATE.**—The amendments made by this section shall apply to calendar quarters beginning on or after January 1, 1991, without regard to whether or not regulations to implement such amendments are promulgated by such date; except that the amendments made by subsection (e) shall apply to determinations of income for months beginning with January 1991.

PART 3—IMPROVEMENTS IN CHILD HEALTH

SEC. 4601. MEDICAID CHILD HEALTH PROVISIONS.

(a) **PHASED-IN MANDATORY COVERAGE OF CHILDREN UP TO 100 PERCENT OF POVERTY LEVEL.**—

(1) **IN GENERAL.**—Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(i)—

(i) by striking "or" at the end of subclause (V),

(ii) by striking the semicolon at the end of subclause (VI) and inserting ", or", and

(iii) by adding at the end the following new subclause:

"(VII) who are described in subparagraph (D) of subsection (1)(1) and whose family income does not exceed the income level the State is required to establish under subsection (1)(2)(C) for such a family;"

(B) in subsection (a)(10)(A)(ii)(IX), by striking "or clause (i)(VI)" and inserting ", clause (i)(VI), or clause (i)(VII)";

(C) in subsection (1)—

(i) in subparagraph (C) of paragraph (1) by inserting "children" after "(C)";

(ii) by striking subparagraph (D) of paragraph (1) and inserting the following:

"(D) children born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age,"

(iii) by striking subparagraph (C) of paragraph (2) and inserting the following:

"(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.";

(iv) in paragraph (3) by inserting "~~(a)(10)(A)(i)(VII)~~," after "~~(a)(10)(A)(i)(VI)~~";

(v) in paragraph (4)(A), by inserting "or subsection ~~(a)(10)(A)(i)(VII)~~" after "~~(a)(10)(A)(i)(VI)~~"; and

(vi) in paragraph (4)(B), by striking "~~(a)(10)(A)(i)(VI)~~" and inserting "~~(a)(10)(A)(i)(VI)~~, or ~~(a)(10)(A)(i)(VII)~~"; and

(D) in subsection ~~(r)(2)(A)~~, by inserting "~~(a)(10)(A)(i)(VII)~~," after "~~(a)(10)(A)(i)(VI)~~,".

(2) CONFORMING AMENDMENT TO QUALIFIED CHILDREN.—Section 1905(n)(2) (42 U.S.C. 1396d(n)(2)) is amended by striking "age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8)" and inserting "age of 19".

(3) ADDITIONAL CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended—

(i) by striking "~~1902(a)(10)(A)(i)(IV)~~," and inserting "~~1902(a)(10)(A)(i)(III)~~, ~~1902(a)(10)(A)(i)(IV)~~, ~~1902(a)(10)(A)(i)(V)~~," and

(ii) by inserting "~~1902(a)(10)(A)(i)(VII)~~," after "~~1902(a)(10)(A)(i)(VI)~~,".

(B) Subsections ~~(a)(3)(C)~~ and ~~(b)(3)(C)(i)~~ of section 1925 of such Act (42 U.S.C. 1396r-6), as amended by section 6411(i)(3) of the Omnibus Budget Reconciliation Act of 1989, are each amended by inserting "~~(i)(VII)~~," after "~~(i)(VI)~~".

(b) EFFECTIVE DATE.—(1) The amendments made by this subsection apply (except as otherwise provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 4602. MANDATORY USE OF OUTREACH LOCATIONS OTHER THAN WELFARE OFFICES.

(a) *IN GENERAL.*—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 4401(a)(2) of this title, is amended—

(1) by striking “and” at the end of paragraph (53),

(2) by striking the period at the end of paragraph (54) and inserting “; and”, and

(3) by inserting after paragraph (54) the following new paragraph:

“(55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—

“(A) at locations which are other than those used for the receipt and processing of applications for aid under part A of title IV and which include facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(1)(2)(B), and

“(B) using applications which are other than those used for applications for aid under such part.”

(b) *EFFECTIVE DATE.*—The amendments made by subsection (a) apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 4603. MANDATORY CONTINUATION OF BENEFITS THROUGHOUT PREGNANCY OR FIRST YEAR OF LIFE.

(a) *IN GENERAL.*—Section 1902(e) (42 U.S.C. 1396a(e)) is amended—

(1) in the first sentence of paragraph (4), by inserting “(or would remain if pregnant)” after “remains”; and

(2) in paragraph (6)—

(A) by striking “At the option of a State, in” and inserting “In”;

(B) by striking “the State plan may nonetheless treat the woman as being” and inserting “the woman shall be deemed to continue to be”; and

(C) by adding at the end the following new sentence: “The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1920 during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.”

(b) *EFFECTIVE DATE.*—

(1) *INFANTS.*—The amendment made by subsection (a)(1) shall apply to individuals born on or after January 1, 1991, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

(2) *PREGNANT WOMEN.*—The amendments made by subsection (a)(2) shall apply with respect to determinations to terminate the eligibility of women, based on change of income, made on or

after January 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 4604. ADJUSTMENT IN PAYMENT FOR HOSPITAL SERVICES FURNISHED TO LOW-INCOME CHILDREN UNDER THE AGE OF 6 YEARS.

(a) *IN GENERAL.*—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

“(s) In order to meet the requirements of subsection (a)(55), the State plan must provide that payments to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1923(b)(1), shall—

“(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

“(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

“(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).”.

(b) *CONFORMING AMENDMENT.*—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 4401(a)(2), is further amended—

(1) by striking “and” at the end of paragraph (53);

(2) by striking the period at the end of paragraph (54) and by inserting “; and”; and

(3) by inserting after paragraph (54) and before the end matter the following new paragraph:

“(55) provide, in accordance with subsection (s), for adjusted payments for certain inpatient hospital services.”.

(c) *PROHIBITION ON WAIVER.*—Section 1915(b) (42 U.S.C. 1396n(b)) is amended in the matter preceding paragraph (1) by inserting “(other than subsection (s))” after “Section 1902”.

(d) *EFFECTIVE DATE.*—(1) The amendments made by this subsection shall become effective with respect to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet

these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 4605. PRESUMPTIVE ELIGIBILITY.

(a) EXTENSION OF PRESUMPTIVE ELIGIBILITY PERIOD.—Section 1920 (42 U.S.C. 1396r-1) is amended—

(1) in subsection (b)(1)(B)—

(A) by adding “or” at the end of clause (i),

(B) by striking clause (ii), and

(C) by amending clause (iii) to read as follows:

“(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day; and”; and

(2) in subsections (c)(2)(B) and (c)(3), by striking “within 14 calendar days after the date on which” and inserting “by not later than the last day of the month following the month during which”.

(b) FLEXIBILITY IN APPLICATION.—Section 1920(c)(3) (42 U.S.C. 1396r-1(c)(3)) is amended by inserting before the period at the end the following: “, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1)(A)”.

(c) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) The amendment made by subsection (b) shall be effective as if included in the enactment of section 9407(b) of the Omnibus Budget Reconciliation Act of 1986.

SEC. 4606. ROLE IN PATERNITY DETERMINATIONS.

(a) IN GENERAL.—Section 1912(a)(1)(B) (42 U.S.C. 1396k(a)(1)(B)) is amended by inserting “the individual is described in section 1902(l)(1)(A) or” after “unless (in either case)”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 4607. REPORT AND TRANSITION ON ERRORS IN ELIGIBILITY DETERMINATIONS.

(a) REPORT.—The Secretary of Health and Human Services shall report to Congress, by not later than July 1, 1991, on error rates by States in determining eligibility of individuals described in subparagraph (A) or (B) of section 1902(l)(1) of the Social Security Act for medical assistance under plans approved under title XIX of such Act. Such report may include data for medical assistance provided before July 1, 1989.

(b) **ERROR RATE TRANSITION.**—*There shall not be taken into account, for purposes of section 1903(u) of the Social Security Act, payments and expenditures for medical assistance which—*

(1) *are attributable to medical assistance for individuals described in subparagraph (A) or (B) of section 1902(1)(1) of such Act, and*

(2) *are made on or after July 1, 1989, and before the first calendar quarter that begins more than 12 months after the date of submission of the report under subsection (a).*

PART 4—MISCELLANEOUS

Subpart A—Payments

SEC. 4701. STATE MEDICAID MATCHING PAYMENTS THROUGH VOLUNTARY CONTRIBUTIONS AND STATE TAXES.

(a) **EXTENSION OF PROVISION ON VOLUNTARY CONTRIBUTIONS AND PROVIDER-SPECIFIC TAXES.**—*Section 8431 of the Technical and Miscellaneous Revenue Act of 1988 is amended by striking “December 31, 1990” and inserting “December 31, 1991”.*

(b) **STATE TAX CONTRIBUTIONS.**—(1) *Section 1902 (42 U.S.C. 1396a) as amended by section 4604, is further amended by adding at the end the following new subsection:*

“(t) Except as provided in section 1903(i), nothing in this title (including sections 1903(a) and 1905(a)) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services.”.

(2) *Section 1903(i) (42 U.S.C. 1396b(i)) is amended—*

(A) *by striking the period at the end of paragraph (9) and inserting “; or”; and*

(B) *by adding at the end the following new paragraph:*

“(10) with respect to any amount expended for medical assistance for care or services furnished by a hospital, nursing facility, or intermediate care facility for the mentally retarded to reimburse the hospital or facility for the costs attributable to taxes imposed by the State solely with respect to hospitals or facilities.”.

(c) **EFFECTIVE DATES.**—*The amendment made by subsection (b) shall take effect on January 1, 1991.*

SEC. 4702. DISPROPORTIONATE SHARE HOSPITALS: COUNTING OF INPATIENT DAYS.

(a) **CLARIFICATION OF MEDICAID DISPROPORTIONATE SHARE ADJUSTMENT CALCULATION.**—*Section 1923(b)(2) (42 U.S.C. 1396r-4(b)(2)) is amended by adding at the end the following new sentence: “In this paragraph, the term ‘inpatient day’ includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.”.*

(b) **EFFECTIVE DATE.**—*The amendment made by subsection (a) shall take effect on July 1, 1990.*

SEC. 4703. DISPROPORTIONATE SHARE HOSPITALS: ALTERNATIVE STATE PAYMENT ADJUSTMENTS AND SYSTEMS.

(a) **ALTERNATIVE STATE PAYMENT ADJUSTMENTS.**—Section 1923(c) (42 U.S.C. 1396r-4(c)) is amended—

- (1) by striking “or” at the end of paragraph (1);
- (2) by adding “or” at the end of paragraph (2); and
- (3) by inserting after paragraph (2) the following new paragraph:

“(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

“(A) applies equally to all hospitals of each type; and

“(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this title or to low-income patients.”.

(b) **CLARIFICATION OF SPECIAL RULE FOR STATE USING HEALTH INSURING ORGANIZATION.**—Section 1923(e)(2) (42 U.S.C. 1396r-4(e)(2)) is amended by striking “during the 3-year period”.

(c) **CONFORMING AMENDMENT.**—Section 1923(c)(2) (42 U.S.C. 1396r-4(c)(2)) is amended by inserting after “State” “or the hospital’s low-income utilization rate (as defined in paragraph (b)(3))”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall take effect as if included in the enactment of section 412(a)(2) of the Omnibus Budget Reconciliation Act of 1987.

SEC. 4704. FEDERALLY QUALIFIED HEALTH CENTERS.

(a) **CLARIFICATION OF USE OF MEDICARE PAYMENT METHODOLOGY.**—Section 1902(a)(13)(E) (42 U.S.C. 1396a(a)(13)(E)) is amended—

(1) by striking “may prescribe” the first place it appears and inserting “prescribes”, and

(2) by striking “on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph” and inserting “on the same methodology used under section 1833(a)(3)”.

(b) **MINIMUM PAYMENT RATES BY HEALTH MAINTENANCE ORGANIZATIONS.**—(1) Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) by striking “and” at the end of clause (vii),

(B) by striking the period at the end of clause (viii) and inserting “, and”, and

(C) by adding at the end the following new clause:

“(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services of such center with a federally qualified health center, that (I) rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1902(a)(13)(E), and (II) at the election of such center payments made by the entity to such a center for services described in 1905(a)(2)(C) are made at the rates of payment specified in section 1902(a)(13)(E).”.

(2) Section 1903(m)(2)(B) (42 U.S.C. 1396b(m)(2)(A)) is amended by striking "(A)" and inserting "(A) except with respect to clause (ix) of subparagraph (A),".

(3) Section 1915(b) (42 U.S.C. 1396n(b)) is amended by inserting after "section 1902" "(other than sections 1902(a)(13)(E) and 1902(a)(10)(A) insofar as it requires provision of the care and services described in section 1905(a)(2)(C))".

(c) **CLARIFICATION IN TREATMENT OF OUTPATIENTS.**—Section 1905(l)(2) (42 U.S.C. 1396d(l)(2)) is amended—

(1) in subparagraph (A), by striking "outpatient" and inserting "patient",

(2) in subparagraph (B), by striking "facility" and inserting "entity", and

(3) by redesignating clause (ii) as clause (iii) and by inserting after clause (i) the following new clause:

"(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

"(II) meets the requirements to receive a grant under section 329, 330, or 340 of such Act;".

(d) **TREATMENT OF INDIAN TRIBES.**—The first sentence of section 1905(l)(2)(B) (42 U.S.C. 1396d(l)(2)(B)) is amended—

(1) by striking the period at the end and inserting a comma, and

(2) by adding, after and below clause (ii), the following:

"and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).".

(e) **TECHNICAL CORRECTION.**—Section 6402 of the Omnibus Budget Reconciliation Act of 1989 is amended—

(1) by striking subsection (c), and

(2) by amending subsection (d) to read as follows:

"(c) **EFFECTIVE DATE.**—The amendments made by this section (except as otherwise provided in such amendments) shall take effect on the date of the enactment of this Act.".

(f) **EFFECTIVE DATE.**—The amendments made by this section shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989.

SEC. 4705. HOSPICE PAYMENTS.

(a) **IN GENERAL.**—Section 1905(o)(3) (42 U.S.C. 1396d(o)(3)) is amended—

(1) by striking "a State which elects" and all that follows through "with respect to" the first place it appears,

(2) by striking "skilled nursing or intermediate care facility" in subparagraphs (A) and (C) and inserting "nursing facility or intermediate care facility for the mentally retarded";

(3) by striking "the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1902(a)(13)," and inserting "the additional amount described in section 1902(a)(13)(D)", and

(4) by striking the last sentence.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall be effective as if included in the amendments made by section 6408(c)(1) of the Omnibus Budget Reconciliation Act of 1989.

SEC. 4706. LIMITATION ON DISALLOWANCES OR DEFERRAL OF FEDERAL FINANCIAL PARTICIPATION FOR CERTAIN INPATIENT PSYCHIATRIC HOSPITAL SERVICES FOR INDIVIDUALS UNDER AGE 21.

(a) **IN GENERAL.**—(1) If the Secretary of Health and Human Services makes a determination that a psychiatric facility has failed to comply with certification of need requirements for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(h) of the Social Security Act, and such determination has not been subject to a final judicial decision, any disallowance or deferral of Federal financial participation under such Act based on such determination shall only apply to the period of time beginning with the first day of noncompliance and ending with the date by which the psychiatric facility develops documentation (using plan of care or utilization review procedures) of the need for inpatient care with respect to such individuals.

(2) Any disallowance of Federal financial participation under title XIX of the Social Security Act relating to the failure of a psychiatric facility to comply with certification of need requirements—

(A) shall not exceed 25 percent of the amount of Federal financial participation for the period described in paragraph (1); and

(B) shall not apply to any fiscal year before the fiscal year that is 3 years before the fiscal year in which the determination of noncompliance described in paragraph (1) is made.

(b) **EFFECTIVE DATE.**—Subsection (a) shall apply to disallowance actions and deferrals of Federal financial participation with respect to services provided before the date of enactment of this Act.

SEC. 4707. TREATMENT OF INTEREST ON INDIANA DISALLOWANCE.

With respect to any disallowance of Federal financial participation under section 1903(a) of the Social Security Act for intermediate care facility services, intermediate care facility services for the mentally retarded, or skilled nursing facility services on the ground that the facilities in the State of Indiana were not certified in accordance with law during the period beginning June 1, 1982, and ending September 30, 1984, payment of such disallowance may be deferred without interest that would otherwise accrue without regard to this subsection, until every opportunity to appeal has been exhausted.

SEC. 4708. BILLING FOR SERVICES OF SUBSTITUTE PHYSICIAN.

(a) **UNDER MEDICAID.**—Section 1902(a)(32) (42 U.S.C. 1396a(a)(32))—

(1) by striking “and” before “(B)”,

(2) by inserting “and” at the end of subparagraph (B), and

(3) by adding at the end the following:

“(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were fur-

nished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services."

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after the date of the enactment of this Act.

Subpart B—Eligibility and Coverage

SEC. 4711. HOME AND COMMUNITY-BASED CARE AS OPTIONAL SERVICE.

(a) **PROVISION AS OPTIONAL SERVICE.**—Section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 6201, is further amended—

(1) by striking "and" at the end of paragraph (22);

(2) by redesignating paragraph (23) as paragraph (24); and

(3) by inserting after paragraph (22) the following new paragraph:

"(23) home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals; and"

(b) **HOME AND COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS.**—Title XIX (42 U.S.C. 1396 et seq.) as amended by section 4402 is further amended—

(1) by redesignating section 1929 as section 1930; and

(2) by inserting after section 1928 the following new section:

"HOME AND COMMUNITY CARE FOR FUNCTIONALLY DISABLED ELDERLY INDIVIDUALS

"**SEC. 1929. (a) HOME AND COMMUNITY CARE DEFINED.**—In this title, the term 'home and community care' means one or more of the following services furnished to an individual who has been determined, after an assessment under subsection (c), to be a functionally disabled elderly individual, furnished in accordance with an individual community care plan (established and periodically reviewed and revised by a qualified community care case manager under subsection (d)):

"(1) Homemaker/home health aide services.

"(2) Chore services.

"(3) Personal care services.

"(4) Nursing care services provided by, or under the supervision of, a registered nurse.

"(5) Respite care.

"(6) Training for family members in managing the individual.

"(7) Adult day care.

"(8) In the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility).

"(9) Such other home and community-based services (other than room and board) as the Secretary may approve.

"(b) FUNCTIONALLY DISABLED ELDERLY INDIVIDUAL DEFINED.—

"(1) **IN GENERAL.**—In this title, the term 'functionally disabled elderly individual' means an individual who—

"(A) is 65 years of age or older,

"(B) is determined to be a functionally disabled individual under subsection (c), and

"(C) subject to section 1902(f) (as applied consistent with section 1902(r)(2)), is receiving supplemental security income benefits under title XVI (or under a State plan approved under title XVI) or, at the option of the State, is described in section 1902(a)(10)(C).

"(2) TREATMENT OF CERTAIN INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER.—*(A) In the case of a State which—*

"(i) at the time of its election to provide coverage for home and community care under this section has a waiver approved under section 1915(c) or 1915(d) with respect to individuals 65 years of age or older, and

"(ii) subsequently discontinues such waiver, individuals who were eligible for benefits under the waiver as of the date of its discontinuance and who would, but for income or resources, be eligible for medical assistance for home and community care under the plan shall, notwithstanding any other provision of this title, be deemed a functionally disabled elderly individual for so long as the individual would have remained eligible for medical assistance under such waiver.

"(B) In the case of a State which used a health insuring organization before January 1, 1986, and which, as of December 31, 1990, had in effect a waiver under section 1115 that provides under the State plan under this title for personal care services for functionally disabled individuals, the term 'functionally disabled elderly individual' may include, at the option of the State, an individual who—

"(i) is 65 years of age or older or is disabled (as determined under the supplemental security income program under title XVI);

"(ii) is determined to meet the test of functional disability applied under the waiver as of such date; and

"(iii) meets the resource requirement and income standard that apply in the State to individuals described in section 1902(a)(10)(A)(ii)(V).

"(3) USE OF PROJECTED INCOME.—*In applying section 1903(f)(1) in determining the eligibility of an individual (described in section 1902(a)(10)(C)) for medical assistance for home and community care, a State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income) over a period of up to 6 months.*

"(c) DETERMINATIONS OF FUNCTIONAL DISABILITY.—

"(1) IN GENERAL.—*In this section, an individual is 'functionally disabled' if the individual—*

"(A) is unable to perform without substantial assistance from another individual at least 2 of the following 3 activities of daily living: toileting, transferring, and eating; or

"(B) has a primary or secondary diagnosis of Alzheimer's disease and is (i) unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision at least 2 of the following 5 activities

of daily living: bathing, dressing, toileting, transferring, and eating; or (ii) cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors that pose serious health or safety hazards to himself or herself or others.

"(2) ASSESSMENTS OF FUNCTIONAL DISABILITY.—

"(A) REQUESTS FOR ASSESSMENTS.—If a State has elected to provide home and community care under this section, upon the request of an individual who is 65 years of age or older and who meets the requirements of subsection (b)(1)(C) (or another person on such individual's behalf), the State shall provide for a comprehensive functional assessment under this subparagraph which—

"(i) is used to determine whether or not the individual is functionally disabled,

"(ii) is based on a uniform minimum data set specified by the Secretary under subparagraph (C)(i), and

"(iii) uses an instrument which has been specified by the State under subparagraph (B).

No fee may be charged for such an assessment.

"(B) SPECIFICATION OF ASSESSMENT INSTRUMENT.—The State shall specify the instrument to be used in the State in complying with the requirement of subparagraph (A)(iii) which instrument shall be—

"(i) one of the instruments designated under subparagraph (C)(ii); or

"(ii) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary in subparagraph (C)(i).

"(C) SPECIFICATION OF ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

"(i) not later than July 1, 1991—

"(I) specify a minimum data set of core elements and common definitions for use in conducting the assessments required under subparagraph (A); and

"(II) establish guidelines for use of the data set; and

"(ii) by not later than July 1, 1991, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subparagraph (B) for use in complying with the requirements of subparagraph (A).

"(D) PERIODIC REVIEW.—Each individual who qualifies as a functionally disabled elderly individual shall have the individual's assessment periodically reviewed and revised not less often than once every 12 months.

"(E) CONDUCT OF ASSESSMENT BY INTERDISCIPLINARY TEAMS.—An assessment under subparagraph (A) and a review under subparagraph (D) must be conducted by an interdisciplinary team designated by the State. The Secretary shall permit a State to provide for assessments and reviews through teams under contracts—

"(i) with public organizations; or

“(ii) with nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, community care or nursing facility services.

“(F) **CONTENTS OF ASSESSMENT.**—The interdisciplinary team must—

“(i) identify in each such assessment or review each individual’s functional disabilities and need for home and community care, including information about the individual’s health status, home and community environment, and informal support system; and

“(ii) based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

The results of such an assessment or review shall be used in establishing, reviewing, and revising the individual’s ICCP under subsection (d)(1).

“(G) **APPEAL PROCEDURES.**—Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (F).

“(d) **INDIVIDUAL COMMUNITY CARE PLAN (ICCP).**—

“(1) **INDIVIDUAL COMMUNITY CARE PLAN DEFINED.**—In this section, the terms ‘individual community care plan’ and ‘ICCP’ mean, with respect to a functionally disabled elderly individual, a written plan which—

“(A) is established, and is periodically reviewed and revised, by a qualified case manager after a face-to-face interview with the individual or primary caregiver and based upon the most recent comprehensive functional assessment of such individual conducted under subsection (c)(2);

“(B) specifies, within any amount, duration, and scope limitations imposed on home and community care provided under the State plan, the home and community care to be provided to such individual under the plan, and indicates the individual’s preferences for the types and providers of services; and

“(C) may specify other services required by such individual.

An ICCP may also designate the specific providers (qualified to provide home and community care under the State plan) which will provide the home and community care described in subparagraph (B). Nothing in this section shall be construed as authorizing an ICCP or the State to restrict the specific persons or individuals (who are competent to provide home and community care under the State plan) who will provide the home and community care described in subparagraph (B).

“(2) **QUALIFIED COMMUNITY CARE CASE MANAGER DEFINED.**—In this section, the term ‘qualified community care case manager’ means a nonprofit or public agency or organization which—

"(A) has experience or has been trained in establishing, and in periodically reviewing and revising, individual community care plans and in the provision of case management services to the elderly;

"(B) is responsible for (i) assuring that home and community care covered under the State plan and specified in the ICCP is being provided, (ii) visiting each individual's home or community setting where care is being provided not less often than once every 90 days, and (iii) informing the elderly individual or primary caregiver on how to contact the case manager if service providers fail to properly provide services or other similar problems occur;

"(C) in the case of a nonpublic agency, does not provide home and community care or nursing facility services and does not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, home and community care or nursing facility services;

"(D) has procedures for assuring the quality of case management services that includes a peer review process;

"(E) completes the ICCP in a timely manner and reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers; and

"(F) meets such other standards, established by the Secretary, as to assure that—

"(i) such a manager is competent to perform case management functions;

"(ii) individuals whose home and community care they manage are not at risk of financial exploitation due to such a manager; and

"(iii) meets such other standards as the State may establish.

The Secretary may waive the requirement of subparagraph (C) in the case of a nonprofit agency located in a rural area.

"(3) **APPEALS PROCESS.**—Each State which elects to provide home and community care under this section must have in effect an appeals process for individuals who disagree with the ICCP established.

"(e) **CEILING ON PAYMENT AMOUNTS AND MAINTENANCE OF EFFORT.**—

"(1) **CEILING ON PAYMENT AMOUNTS.**—Payments may not be made under section 1903(a) to a State for home and community care provided under this section in a quarter to the extent that the medical assistance for such care in the quarter exceeds 50 percent of the product of—

"(A) the average number of individuals in the quarter receiving such care under this section;

"(B) the average per diem rate of payment which the Secretary has determined (before the beginning of the quarter) will be payable under title XVIII (without regard to coinsurance) for extended care services to be provided in the State during such quarter; and

"(C) the number of days in such quarter.

"(2) **MAINTENANCE OF EFFORT.**—

"(A) ANNUAL REPORTS.—As a condition for the receipt of payment under section 1903(a) with respect to medical assistance provided by a State for home and community care (other than a waiver under section 1915(c) and other than home health care services described in section 1905(a)(7) and personal care services specified under regulations under section 1905(a)(23)), the State shall report to the Secretary, with respect to each Federal fiscal year (beginning with fiscal year 1990) and in a format developed or approved by the Secretary, the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year.

"(B) REDUCTION IN PAYMENT IF FAILURE TO MAINTAIN EFFORT.—If the amount reported under subparagraph (A) by a State with respect to a fiscal year is less than the amount reported under subparagraph (A) with respect to fiscal year 1989, the Secretary shall provide for a reduction in payments to the State under section 1903(a) in an amount equal to the difference between the amounts so reported.

"(f) MINIMUM REQUIREMENTS FOR HOME AND COMMUNITY CARE.—

"(1) REQUIREMENTS.—Home and Community care provided under this section must meet such requirements for individuals' rights and quality as are published or developed by the Secretary under subsection (k). Such requirements shall include—

"(A) the requirement that individuals providing care are competent to provide such care; and

"(B) the rights specified in paragraph (2).

"(2) SPECIFIED RIGHTS.—The rights specified in this paragraph are as follows:

"(A) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

"(B) The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities.

"(C) The right to confidentiality of personal and clinical records.

"(D) The right to privacy and to have one's property treated with respect.

"(E) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

"(F) The right to education or training for oneself and for members of one's family or household on the management of care.

"(G) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical re-

straints imposed for purposes of discipline or convenience and not included in an individual's ICCP.

"(H) The right to be fully informed orally and in writing of the individual's rights.

"(I) Guidelines for such minimum compensation for individuals providing such care as will assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

"(J) Any other rights established by the Secretary.

"(g) MINIMUM REQUIREMENTS FOR SMALL COMMUNITY CARE SETTINGS.—

"(1) SMALL COMMUNITY CARE SETTINGS DEFINED.—In this section, the term 'small community care setting' means—

"(A) a nonresidential setting that serves more than 2 and less than 8 individuals; or

"(B) a residential setting in which more than 2 and less than 8 unrelated adults reside and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

"(2) MINIMUM REQUIREMENTS.—A small community care setting in which community care is provided under this section must—

"(A) meet such requirements as are published or developed by the Secretary under subsection (k);

"(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1919(c), to the extent applicable to such a setting;

"(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting;

"(D) meet any applicable State or local requirements regarding certification or licensure;

"(E) meet any applicable State and local zoning, building, and housing codes, and State and local fire and safety regulations; and

"(F) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents.

"(h) MINIMUM REQUIREMENTS FOR LARGE COMMUNITY CARE SETTINGS.—

"(1) LARGE COMMUNITY CARE SETTING DEFINED.—In this section, the term 'large community care setting' means—

"(A) a nonresidential setting in which more than 8 individuals are served; or

"(B) a residential setting in which more than 8 unrelated adults reside and in which personal services are provided in conjunction with residing in the setting in which home and community care under this section is provided.

"(2) MINIMUM REQUIREMENTS.—A large community care setting in which community care is provided under this section must—

"(A) meet such requirements as are published or developed by the Secretary under subsection (k);

"(B) meet the requirements of paragraphs (1)(A), (1)(C), (1)(D), (3), and (6) of section 1919(c), to the extent applicable to such a setting;

"(C) inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives home and community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting; and

"(D) meet the requirements of paragraphs (2) and (3) of section 1919(d) (relating to administration and other matters) in the same manner as such requirements apply to nursing facilities under such section; except that, in applying the requirement of section 1919(d)(2) (relating to life safety code), the Secretary shall provide for the application of such life safety requirements (if any) that are appropriate to the setting.

"(3) **DISCLOSURE OF OWNERSHIP AND CONTROL INTERESTS AND EXCLUSION OF REPEATED VIOLATORS.**—A community care setting—

"(A) must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3)) in the setting; and

"(B) may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under this title or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard or to have failed to meet the requirements of paragraph (2).

"(i) **SURVEY AND CERTIFICATION PROCESS.**—

"(1) **CERTIFICATIONS.**—

"(A) **RESPONSIBILITIES OF THE STATE.**—Under each State plan under this title, the State shall be responsible for certifying the compliance of providers of home and community care and community care settings with the applicable requirements of subsections (f), (g) and (h). The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

"(B) **RESPONSIBILITIES OF THE SECRETARY.**—The Secretary shall be responsible for certifying the compliance of State providers of home and community care, and of State community care settings in which such care is provided, with the requirements of subsections (f), (g) and (h).

"(C) **FREQUENCY OF CERTIFICATIONS.**—Certification of providers and settings under this subsection shall occur no less frequently than once every 12 months.

"(2) **REVIEWS OF PROVIDERS.**—

"(A) **IN GENERAL.**—The certification under this subsection with respect to a provider of home or community care must be based on a periodic review of the provider's per-

formance in providing the care required under ICCP's in accordance with the requirements of subsection (f).

"(B) SPECIAL REVIEWS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a provider of home or community care with any of the requirements of subsection (f), the Secretary may conduct a review of the provider and, on the basis of that review, make independent and binding determinations concerning the extent to which the provider meets such requirements.

"(3) SURVEYS OF COMMUNITY CARE SETTINGS.—

"(A) IN GENERAL.—The certification under this subsection with respect to community care settings must be based on a survey. Such survey for such a setting must be conducted without prior notice to the setting. Any individual who notifies (or causes to be notified) a community care setting of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed \$2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for scheduling and conducting such surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

"(B) SURVEY PROTOCOL.—Surveys under this paragraph shall be conducted based upon a protocol which the Secretary has provided for under subsection (k).

"(C) PROHIBITION OF CONFLICT OF INTEREST IN SURVEY TEAM MEMBERSHIP.—A State and the Secretary may not use as a member of a survey team under this paragraph an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the community care setting being surveyed (or the person responsible for such setting) respecting compliance with the requirements of subsection (g) or (h) or who has a personal or familial financial interest in the setting being surveyed.

"(D) VALIDATION SURVEYS OF COMMUNITY CARE SETTINGS.—The Secretary shall conduct onsite surveys of a representative sample of community care settings in each State, within 2 months of the date of surveys conducted under subparagraph (A) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under subparagraph (A). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under subparagraph (B). If the State has determined that an individual setting meets the requirements of subsection (g), but the Secretary determines that the setting does not meet such requirements, the Secretary's determination as to the setting's noncompliance with such requirements is binding and supersedes that of the State survey.

"(E) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a community care setting with any of the requirements of subsection (g) or (h), the Secretary may conduct a survey of the setting and, on the basis of that survey, make independent and binding determinations concerning the extent to which the setting meets such requirements.

"(4) INVESTIGATION OF COMPLAINTS AND MONITORING OF PROVIDERS AND SETTINGS.—Each State and the Secretary shall maintain procedures and adequate staff to investigate complaints of violations of applicable requirements imposed on providers of community care or on community care settings under subsections (f), (g) and (h).

"(5) INVESTIGATION OF ALLEGATIONS OF INDIVIDUAL NEGLECT AND ABUSE AND MISAPPROPRIATION OF INDIVIDUAL PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of providers of home or community care and community care settings under this subsection, for a process for the receipt, review, and investigation of allegations of individual neglect and abuse (including injuries of unknown source) by individuals providing such care or in such setting and of misappropriation of individual property by such individuals. The State shall, after notice to the individual involved and a reasonable opportunity for hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that an individual has neglected or abused an individual receiving community care or misappropriated such individual's property, the State shall notify the individual against whom the finding is made. A State shall not make a finding that a person has neglected an individual receiving community care if the person demonstrates that such neglect was caused by factors beyond the control of the person. The State shall provide for public disclosure of findings under this paragraph upon request and for inclusion, in any such disclosure of such findings, of any brief statement (or of a clear and accurate summary thereof) of the individual disputing such findings.

"(6) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

"(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

"(i) information respecting all surveys, reviews, and certifications made under this subsection respecting providers of home or community care and community care settings, including statements of deficiencies,

"(ii) copies of cost reports (if any) of such providers and settings filed under this title,

"(iii) copies of statements of ownership under section 1124, and

"(iv) information disclosed under section 1126.

"(B) NOTICES OF SUBSTANDARD CARE.—If a State finds that—

"(i) a provider of home or community care has provided care of substandard quality with respect to an

individual, the State shall make a reasonable effort to notify promptly (I) an immediate family member of each such individual and (II) individuals receiving home or community care from that provider under this title, or

“(ii) a community care setting is substandard, the State shall make a reasonable effort to notify promptly (I) individuals receiving community care in that setting, and (II) immediate family members of such individuals.

“(C) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys, reviews, and certifications under this subsection.

“(j) ENFORCEMENT PROCESS FOR PROVIDERS OF COMMUNITY CARE.—

“(1) STATE AUTHORITY.—

“(A) IN GENERAL.—If a State finds, on the basis of a review under subsection (i)(2) or otherwise, that a provider of home or community care no longer meets the requirements of this section, the State may terminate the provider's participation under the State plan and may provide in addition for a civil money penalty. Nothing in this subparagraph shall be construed as restricting the remedies available to a State to remedy a provider's deficiencies. If the State finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A) for the period during which it finds that the provider was not in compliance with such requirements.

“(B) CIVIL MONEY PENALTY.—

“(i) IN GENERAL.—Each State shall establish by law (whether statute or regulation) at least the following remedy: A civil money penalty assessed and collected, with interest, for each day in which the provider is or was out of compliance with a requirement of this section. Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty under subsection (i)(3)(A)) may be applied to reimbursement of individuals for personal funds lost due to a failure of home or community care providers to meet the requirements of this section. The State also shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

“(ii) DEADLINE AND GUIDANCE.—Each State which elects to provide home and community care under this

section must establish the civil money penalty remedy described in clause (i) applicable to all providers of community care covered under this section. The Secretary shall provide, through regulations or otherwise by not later than July 1, 1990, guidance to States in establishing such remedy; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedy.

“(2) SECRETARIAL AUTHORITY.—

“(A) FOR STATE PROVIDERS.—With respect to a State provider of home or community care, the Secretary shall have the authority and duties of a State under this subsection, except that the civil money penalty remedy described in subparagraph (C) shall be substituted for the civil money remedy described in paragraph (1)(B)(i).

“(B) OTHER PROVIDERS.—With respect to any other provider of home or community care in a State, if the Secretary finds that a provider no longer meets a requirement of this section, the Secretary may terminate the provider's participation under the State plan and may provide, in addition, for a civil money penalty under subparagraph (C). If the Secretary finds that a provider meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C) for the period during which the Secretary finds that the provider was not in compliance with such requirements.

“(C) CIVIL MONEY PENALTY.—If the Secretary finds on the basis of a review under subsection (i)(2) or otherwise that a home or community care provider no longer meets the requirements of this section, the Secretary shall impose a civil money penalty in an amount not to exceed \$10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall specify criteria, as to when and how this remedy is to be applied and the amounts of any penalties. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the penalties and shall provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

“(k) SECRETARIAL RESPONSIBILITIES.—

“(1) PUBLICATION OF INTERIM REQUIREMENTS.—

“(A) IN GENERAL.—The Secretary shall publish, by December 1, 1991, a proposed regulation that sets forth interim requirements, consistent with subparagraph (B), for the provision of home and community care and for community care settings, including—

“(i) the requirements of subsection (c)(2) (relating to comprehensive functional assessments, including the use of assessment instruments), of subsection (d)(2)(E) (relating to qualifications for qualified case managers),

of subsection (f) (relating to minimum requirements for home and community care), of subsection (g) (relating to minimum requirements for small community care settings), and of subsection (h) (relating to minimum requirements for large community care settings, and

“(ii) survey protocols (for use under subsection (i)(3)(A)) which relate to such requirements.

“(B) **MINIMUM PROTECTIONS.**—Interim requirements under subparagraph (A) and final requirements under paragraph (2) shall assure, through methods other than reliance on State licensure processes, that individuals receiving home and community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings.

“(2) **DEVELOPMENT OF FINAL REQUIREMENTS.**—The Secretary shall develop, by not later than October 1, 1992—

“(A) final requirements, consistent with paragraph (1)(B), respecting the provision of appropriate, quality home and community care and respecting community care settings under this section, and including at least the requirements referred to in paragraph (1)(A)(i), and

“(B) survey protocols and methods for evaluating and assuring the quality of community care settings.

The Secretary may, from time to time, revise such requirements, protocols, and methods.

“(3) **NO DELEGATION TO STATES.**—The Secretary’s authority under this subsection shall not be delegated to States.

“(4) **NO PREVENTION OF MORE STRINGENT REQUIREMENTS BY STATES.**—Nothing in this section shall be construed as preventing States from imposing requirements that are more stringent than the requirements published or developed by the Secretary under this subsection.

“(l) **WAIVER OF STATEWIDENESS.**—States may waive the requirement of section 1902(a)(1) (related to State wideness) for a program of home and community care under this section.

“(m) **LIMITATION ON AMOUNT OF EXPENDITURES AS MEDICAL ASSISTANCE.**—

“(1) **LIMITATION ON AMOUNT.**—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, \$40,000,000, for fiscal year 1992, \$70,000,000, for fiscal year 1993, \$130,000,000, for fiscal year 1994, \$160,000,000, and for fiscal year 1995, \$180,000,000.

“(2) **ASSURANCE OF ENTITLEMENT TO SERVICE.**—A State which receives Federal medical assistance for expenditures for home and community care under this section must provide home and community care specified under the Individual Community Care Plan under subsection (d) to individuals described in subsection (b) for the duration of the election period, without regard to the amount of funds available to the State under paragraph (1). For purposes of this paragraph, an election period is the period of 4 or more calendar quarters elected by

the State, and approved by the Secretary, for the provision of home and community care under this section.

"(3) *LIMITATION ON ELIGIBILITY.*—The State may limit eligibility for home and community care under this section during an election period under paragraph (2) to reasonable classifications (based on age, degree of functional disability, and need for services).

"(4) *ALLOCATION OF MEDICAL ASSISTANCE.*—The Secretary shall establish a limitation on the amount of Federal medical assistance available to any State during the State's election period under paragraph (2). The limitation under this paragraph shall take into account the limitation under paragraph (1) and the number of elderly individuals age 65 or over residing in such State in relation to the number of such elderly individuals in the United States during 1990. For purposes of the previous sentence, elderly individuals shall, to the maximum extent practicable, be low-income elderly individuals."

(c) *PAYMENT FOR HOME AND COMMUNITY CARE.*—

(1) *REASONABLE AND ADEQUATE PAYMENT RATES.*—Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(13)—

(i) by striking "and" at the end of subparagraph (D),

(ii) by inserting "and" at the end of subparagraph (E), and

(iii) by adding at the end the following new subparagraph:

"(F) for payment for home and community care (as defined in section 1929(a) and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;" and

(B) in subsection (h), by adding before the period at the end the following: "or to limit the amount of payment that may be made under a plan under this title for home and community care".

(2) *DENIAL OF PAYMENT FOR CIVIL MONEY PENALTIES, ETC.*—Section 1903(i)(8) of such Act (42 U.S.C. 1396b(i)(8)) is amended by inserting "(A)" after "medical assistance" and by inserting before the semicolon at the end the following: "or (B) for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this title or title XI or for legal expenses in defense of an exclusion or civil money penalty under this title or title XI if there is no reasonable legal ground for the provider's case".

(d) *CONFORMING AMENDMENTS.*—

(1) Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking "(21)" and inserting "(22)".

(2) Section 1902(a)(10)(C)(iv) (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking "through (20)" and inserting "through (21)".

(e) *EFFECTIVE DATES.*—

(1) *Except as provided in this subsection, the amendments made by this section shall apply to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.*

(2)(A) *The amendments made by subsection (c)(1) shall apply to home and community care furnished on or after July 1, 1991, or, if later, 30 days after the date of publication of interim regulations under section 1929(k)(1).*

(B) *The amendment made by subsection (c)(2) shall apply to civil money penalties imposed after the date of the enactment of this Act.*

(f) **WAIVER OF PAPERWORK REDUCTION, ETC.**—Chapter 35 of title 44, United States Code, and Executive Order 12291 shall not apply to information and regulations required for purposes of carrying out this Act and implementing the amendments made by this Act.

SEC. 4712. COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES.

(a) **PROVISION AS OPTIONAL SERVICE.**—Section 1905(a) (42 U.S.C. 1396d(a)) as amended by section 4711 is further amended—

(1) *by striking “and” at the end of paragraph (23);*

(2) *by redesignating paragraph (24) as paragraph (25); and*

(3) *by inserting after paragraph (23) the following new paragraph:*

“(24) community supported living arrangements services (to the extent allowed and as defined in section 1930).”

(b) **COMMUNITY SUPPORTED LIVING ARRANGEMENTS.**—Title XIX (42 U.S.C. 1396 et seq.) as amended by sections 4402 and 4711 is further amended—

(1) *by redesignating section 1930 as section 1931; and*

(2) *by inserting after section 1929 the following new section:*

“COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES

“SEC. 1930. (a) COMMUNITY SUPPORTED LIVING ARRANGEMENTS SERVICES.—In this title, the term ‘community supported living arrangements services’ means one or more of the following services meeting the requirements of subsection (h) provided in a State eligible to provide services under this section (as defined in subsection (d)) to assist a developmentally disabled individual (as defined in subsection (b)) in activities of daily living necessary to permit such individual to live in the individual’s own home, apartment, family home, or rental unit furnished in a community supported living arrangement setting:

“(1) Personal assistance.

“(2) Training and habilitation services (necessary to assist the individual in achieving increased integration, independence and productivity).

“(3) 24-hour emergency assistance (as defined by the Secretary).

“(4) Assistive technology.

“(5) Adaptive equipment.

“(6) Other services (as approved by the Secretary, except those services described in subsection (g)).

"(7) Support services necessary to aid an individual to participate in community activities.

"(b) **DEVELOPMENTALLY DISABLED INDIVIDUAL DEFINED.**—In this title the term, 'developmentally disabled individual' means an individual who as defined by the Secretary is described within the term 'mental retardation and related conditions' as defined in regulations as in effect on July 1, 1990, and who is residing with the individual's family or legal guardian in such individual's own home in which no more than 3 other recipients of services under this section are residing and without regard to whether or not such individual is at risk of institutionalization (as defined by the Secretary).

"(c) **CRITERIA FOR SELECTION OF PARTICIPATING STATES.**—The Secretary shall develop criteria to review the applications of States submitted under this section to provide community supported living arrangement services. The Secretary shall provide in such criteria that during the first 5 years of the provision of services under this section that no less than 2 and no more than 8 States shall be allowed to receive Federal financial participation for providing the services described in this section.

"(d) **QUALITY ASSURANCE.**—A State selected by the Secretary to provide services under this section shall in order to continue to receive Federal financial participation for providing services under this section be required to establish and maintain a quality assurance program, that provides that—

"(1) the State will certify and survey providers of services under this section (such surveys to be unannounced and average at least 1 a year);

"(2) the State will adopt standards for survey and certification that include—

"(A) minimum qualifications and training requirements for provider staff;

"(B) financial operating standards; and

"(C) a consumer grievance process;

"(3) the State will provide a system that allows for monitoring boards consisting of providers, family members, consumers, and neighbors;

"(4) the State will establish reporting procedures to make available information to the public;

"(5) the State will provide ongoing monitoring of the health and well-being of each recipient;

"(6) the State will provide the services defined in subsection (a) in accordance with an individual support plan (as defined by the Secretary in regulations); and

"(7) the State plan amendment under this section shall be reviewed by the State Planning Council established under section 124 of the Developmental Disabilities Assistance and Bill of Rights Act, and the Protection and Advocacy System established under section 142 of such Act.

The Secretary shall not approve a quality assurance plan under this subsection and allow a State to continue to receive Federal financial participation under this section unless the State provides for public hearings on the plan prior to adoption and implementation of its plan under this subsection.

“(e) MAINTENANCE OF EFFORT.—States selected by the Secretary to receive Federal financial participation to provide services under this section shall maintain current levels of spending for such services in order to be eligible to continue to receive Federal financial participation for the provision of such services under this section.

“(f) EXCLUDED SERVICES.—No Federal financial participation shall be allowed for the provision of the following services under this section:

“(1) Room and board.

“(2) Cost of prevocational, vocational and supported employment.

“(g) WAIVER OF REQUIREMENTS.—The Secretary may waive such provisions of this title as necessary to carry out the provisions of this section including the following requirements of this title—

“(1) comparability of amount, duration, and scope of services; and

“(2) statewideness.

“(h) MINIMUM PROTECTIONS.—

“(1) PUBLICATION OF INTERIM AND FINAL REQUIREMENTS.—

“(A) IN GENERAL.—The Secretary shall publish, by July 1, 1991, a regulation (that shall be effective on an interim basis pending the promulgation of final regulations), and by October 1, 1992, a final regulation, that sets forth interim and final requirements, respectively, consistent with subparagraph (B), to protect the health, safety, and welfare of individuals receiving community supported living arrangements services.

“(B) MINIMUM PROTECTIONS.—Interim and final requirements under subparagraph (A) shall assure, through methods other than reliance on State licensure processes or the State quality assurance programs under subsection (d), that—

“(i) individuals receiving community supported living arrangements services are protected from neglect, physical and sexual abuse, and financial exploitation;

“(ii) a provider of community supported living arrangements services may not use individuals who have been convicted of child or client abuse, neglect, or mistreatment or of a felony involving physical harm to an individual and shall take all reasonable steps to determine whether applicants for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment or a criminal record involving physical harm to an individual;

“(iii) individuals or entities delivering such services are not unjustly enriched as a result of abusive financial arrangements (such as owner lease-backs); and

“(iv) individuals or entities delivering such services to clients, or relatives of such individuals, are prohibited from being named beneficiaries of life insurance policies purchased by (or on behalf of) such clients.

“(2) SPECIFIED REMEDIES.—If the Secretary finds that a provider has not met an applicable requirement under subsection (h), the Secretary shall impose a civil money penalty in an

amount not to exceed \$10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(i) **TREATMENT OF FUNDS.**—Any funds expended under this section for medical assistance shall be in addition to funds expended for any existing services covered under the State plan, including any waiver services for which an individual receiving services under this program is already eligible.

“(j) **LIMITATION ON AMOUNTS OF EXPENDITURES AS MEDICAL ASSISTANCE.**—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be for fiscal year 1991, \$5,000,000, for fiscal year 1992, \$10,000,000, for fiscal year 1993, \$20,000,000, for fiscal year 1994, \$30,000,000, for fiscal year 1995, \$35,000,000, and for fiscal years thereafter such sums as provided by Congress.”

(c) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—The amendments made by this section shall apply to community supported living arrangements services furnished on or after the later of July 1, 1991, or 30 days after the publication of regulations setting forth interim requirements under subsection (h) without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) **APPLICATION PROCESS.**—The Secretary of Health and Human Services shall provide that the applications required to be submitted by States under this section shall be received and approved prior to the effective date specified in paragraph (1).

SEC. 4713. PROVIDING FEDERAL MEDICAL ASSISTANCE FOR PAYMENTS FOR PREMIUMS FOR “COBRA” CONTINUATION COVERAGE WHERE COST EFFECTIVE.

(a) **OPTIONAL PAYMENT OF COBRA PREMIUMS FOR QUALIFIED COBRA CONTINUATION BENEFICIARIES.**—Section 1902 (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(10)—

(A) by striking “and” at the end of subparagraph (D),

(B) by adding “and” at the end of subparagraph (E),

(C) by inserting after subparagraph (E) the following new subparagraph:

“(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in section 1902(u)(1);” and

(D) in the matter following subparagraph (E), by striking “and” before “(X)” and by inserting before the semicolon at the end the following: “; and (XI) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2))”; and

(2) by adding after the subsections added by section 4604 and 4701(b) the following new subsection:

*“(u)(1) Individuals described in this paragraph are individuals—
“(A) who are entitled to elect COBRA continuation coverage
(as defined in paragraph (3)),*

“(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

“(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

“(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this title resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

“(2) For purposes of subsection (a)(10)(F) and this subsection, the term ‘COBRA premiums’ means the applicable premium imposed with respect to COBRA continuation coverage.

“(3) In this subsection, the term ‘COBRA continuation coverage’ means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

“(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI)—

“(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

“(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17), require or permit such treatment for other individuals.”

(b) CONFORMING AMENDMENT.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

(1) by striking “or” at the end of clause (viii),

(2) by adding “or” at the end of clause (ix), and

(3) by inserting after clause (ix) the following new clause:

“(x) individuals described in section 1902(u)(1),”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance furnished on or after January 1, 1991.

SEC. 4714. PROVISIONS RELATING TO SPOUSAL IMPOVERISHMENT.

(a) CLARIFICATION OF NON-APPLICATION OF STATE COMMUNITY PROPERTY LAWS.—Section 1924(b)(2) (42 U.S.C. 1396r-1(b)(2)) as amended by subsection (a), is further amended by striking “, after the institutionalized spouse has been determined or redetermined to be eligible for medical assistance” and inserting “for purposes of the post-eligibility income determination described in subsection (d)”.

(b) **CLARIFICATION OF TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.**—Section 1924(f)(1) (42 U.S.C. 1396r-5(f)(1)) is amended by striking “section 1917” and inserting “section 1917(c)(1)”.

(c) **CLARIFICATION OF PERIOD OF CONTINUOUS ELIGIBILITY.**—Section 1924(c)(1) (42 U.S.C. 1396r-1(c)(1)) is amended by striking “the beginning of a continuous period of institutionalization of the institutionalized spouse” each place it appears and inserting “the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse”.

(d) **EFFECTIVE DATE.**—The amendments made this section shall take effect as if included in the enactment of section 303 of the Medicare Catastrophic Coverage Act of 1988.

SEC. 4715. DISREGARDING GERMAN REPARATION PAYMENTS FROM POST-ELIGIBILITY TREATMENT OF INCOME UNDER THE MEDICAID PROGRAM.

(a) **IN GENERAL.**—Section 1902(r)(1) (42 U.S.C. 1396a(r)(1)) is amended by inserting “there shall be disregarded reparation payments made by the Federal Republic of Germany and” after “under such a waiver”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to treatment of income for months beginning more than 30 days after the date of the enactment of this Act.

SEC. 4716. AMENDMENTS RELATING TO MEDICAID TRANSITION PROVISION.

(a) **AMENDMENTS.**—Subsection (f) of section 1925 (42 U.S.C. 1396s) is amended—

(1) in subsection (b)(2)(B)(i), by inserting at the end the following: “A State may permit such additional extended assistance under this subsection notwithstanding a failure to report under this clause if the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis.”;

(2) in subsection (b)(2)(B), by adding at the end the following new clause:

“(iii) **CLARIFICATION ON FREQUENCY OF REPORTING.**—A State may not require that a family receiving extended assistance under this subsection or subsection (a) report more frequently than as required under clause (i) or (ii).”; and

(3) in subsection (b)(3)(B), by adding at the end the following: “No such termination shall be effective earlier than 10 days after the date of mailing of such notice.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall be effective as if included in the enactment of the Family Support Act of 1988.

SEC. 4717. CLARIFYING EFFECT OF HOSPICE ELECTION.

Section 1905(o)(1)(A) (42 U.S.C. 1396d(o)(1)(A)) is amended by inserting “and for which payment may otherwise be made under title XVIII” after “described in section 1812(d)(2)(A)”.

SEC. 4718. MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 1-MEMBER FAMILIES.

(a) **IN GENERAL.**—For purposes of section 1903(f)(1)(B), for payments made before, on, or after the date of the enactment of this Act, a State described in subparagraph (B) may use, in determining

the "highest amount which would ordinarily be paid to a family of the same size" (under the State's plan approved under part A of title IV of such Act) in the case of a family consisting only of one individual and without regard to whether or not such plan provides for aid to families consisting only of one individual, an amount reasonably related to the highest money payment which would ordinarily be made under such a plan to a family of two without income or resources.

(b) **STATES COVERED.**—Subsection (a) shall only apply to a State the State plan of which (under title XIX of the Social Security Act) as of June 1, 1989, provided for the policy described in such paragraph. For purposes of the previous sentence, a State plan includes all the matter included in a State plan under section 2373(c)(5) of the Deficit Reduction Act of 1984 (as amended by section 9 of the Medicare and Medicaid Patient and Program Protection Act of 1987).

SEC. 4719. CODIFICATION OF COVERAGE OF REHABILITATION SERVICES.

(a) **IN GENERAL.**—Section 1905(a)(13) (42 U.S.C. 1396d(a)(13)) is amended by inserting before the semicolon at the end the following: "including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 4720. PERSONAL CARE SERVICES FOR MINNESOTA.

(a) **CLARIFICATION OF COVERAGE.**—In applying section 1905 of the Social Security Act with respect to Minnesota, medical assistance shall include payment for personal care services described in subsection (b).

(b) **PERSONAL CARE SERVICES DEFINED.**—For purposes of this section, the term "personal care services" means services—

(1) prescribed by a physician for an individual in accordance with a plan of treatment,

(2) provided by a person who is qualified to provide such services who is not a member of the individual's family,

(3) supervised by a registered nurse, and

(4) furnished in a home or other location;

but does not include such services furnished to an inpatient or resident of a hospital or nursing facility.

(c) **EFFECTIVE DATE.**—This section shall take effect on the date of the enactment of this Act and shall apply with respect to—

(1) personal care services furnished before such date pursuant to regulations in effect as of July 1, 1989; and

(2) such services furnished before October 1, 1994.

SEC. 4721. MEDICAID COVERAGE OF PERSONAL CARE SERVICES OUTSIDE THE HOME.

(a) **IN GENERAL.**—Section 1905(a)(7) (42 U.S.C. 1396d(a)(7)) is amended by striking "services" and inserting "services including personal care services (A) prescribed by a physician for an individual in accordance with a plan of treatment, (B) provided by an indi-

vidual who is qualified to provide such services and who is not a member of the individual's family, (C) supervised by a registered nurse, and (D) furnished in a home or other location; but not including such services furnished to an inpatient or resident of a nursing facility".

(b) **EFFECTIVE DATE.**—The amendment made by this section shall become effective with respect to personal care services provided on or after October 1, 1994.

SEC. 4722. MEDICAID COVERAGE OF ALCOHOLISM AND DRUG DEPENDENCY TREATMENT SERVICES.

Section 1905(a) of the Social Security Act is amended by adding at the end the following new sentence: "No service (including counseling) shall be excluded from the definition of 'medical assistance' solely because it is provided as a treatment service for alcoholism or drug dependency."

SEC. 4723. MEDICAID SPENDDOWN OPTION.

(a) **IN GENERAL.**—Section 1903(f)(2) (42 U.S.C. 1396b(f)(2)) is amended by—

(1) inserting "(A)" after "(2)"; and

(2) by adding before the period at the end the following: "or, (B) notwithstanding section 1916 at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph."

(b) **CONFORMING AMENDMENT.**—Section 1902(a)(17) (42 U.S.C. 1396a(a)(17)) is amended by inserting after "insurance premiums" ", payments made to the State under section 1903(f)(2)(B),".

SEC. 4724. OPTIONAL STATE MEDICAID DISABILITY DETERMINATIONS INDEPENDENT OF THE SOCIAL SECURITY ADMINISTRATION.

(a) **IN GENERAL.**—Section 1902 (42 U.S.C. 1396a) as amended by this title, is further amended by adding at the end the following new subsection:

"(v)(1) A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1614(a) of the Social Security Act."

Subpart C—Health Maintenance Organizations

SEC. 4731. REGULATION OF INCENTIVE PAYMENTS TO PHYSICIANS.

(a) **PHYSICIAN PAYMENT PLAN.**—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) as amended by this title is further amended—

(1) by striking “, and” at the end of clause (viii) and inserting a semicolon;

(2) by striking the period at the end of clause (ix) and inserting “, and”; and

(3) by adding at the end the following new clause:

“(x) any physician incentive plan that it operates meets the requirements described in section 1876(i)(8).”.

(b) **REPEAL OF PROHIBITION AGAINST PHYSICIAN INCENTIVE PAYMENTS.**—Section 1128A(b)(1) (42 U.S.C. 1320a-7a(b)(1)) is—

(1) **REPEAL OF PROHIBITION.**—Section 1128A(b)(1) (42 U.S.C. 1320a-7a(b)(1)) is amended by striking “or an entity with a contract under section 1903(m)”.

(2) **PENALTIES.**—Section 1903(m)(5)(A) (42 U.S.C. 1396b(m)(5)(A)) is amended—

(A) by striking “or” at the end of clause (iii);

(B) by adding “or” at the end of clause (iv); and

(C) by adding at the end the following new clause:

“(v) fails to comply with the requirements of section 1876(i)(8).”.

(c) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b)(2) shall apply with respect to contract years beginning on or after January 1, 1992, and the amendments made by subsection (b)(1) shall take effect on the date of the enactment of this Act.

SEC. 4732. SPECIAL RULES.

(a) **WAIVER OF 75 PERCENT RULE FOR PUBLIC ENTITIES.**—Section 1903(m)(2)(D) (42 U.S.C. 1396b(m)(2)(D)) is amended by striking “(i) special circumstances warrant such modification or waiver, and (ii)”.

(b) **EXTENDING SPECIAL TREATMENT TO MEDICARE COMPETITIVE MEDICAL PLANS.**—

(1) **6-MONTH MINIMUM ENROLLMENT PERIOD OPTION.**—Section 1902(e)(2)(A) (42 U.S.C. 1396a(e)(2)(A)) is amended by inserting “or with an eligible organization with a contract under section 1876” after “1903(m)(2)(A)”.

(2) **ENROLLMENT LOCK-IN.**—Section 1903(m)(2)(F)(i) (42 U.S.C. 1396b(m)(2)(F)(i)) is amended—

(A) by striking “(G) or” and inserting “(G).”, and

(B) adding at the end the following: “or with an eligible organization with a contract under section 1876 which meets the requirement of subparagraph (A)(ii), or”.

(c) **AUTOMATIC 1-MONTH REENROLLMENT FOR SHORT PERIODS OF INELIGIBILITY.**—Section 1903(m)(2) is amended by adding at the end the following new subparagraph:

“(H) In the case of an individual who—

“(i) in a month is eligible for benefits under this title and enrolled with a health maintenance organization with a contract under this paragraph,

"(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

"(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the health maintenance organization described in clause (i) if the organization continues to have a contract under this paragraph with the State."

(d) *ELIMINATION OF PROVISIONAL QUALIFICATION FOR HMOs.*—Section 1903(m) is amended—

(1) in paragraph (2)(A)(i), by striking "(or the State as authorized by paragraph (3))", and

(2) by striking paragraph (3).

(e) *EFFECTIVE DATE.*—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 4733. EXTENSION AND EXPANSION OF MINNESOTA PREPAID MEDICAID DEMONSTRATION PROJECT.

Section 507 of the Family Support Act of 1988 is amended—

(1) by striking "1991" and inserting "1996"; and

(2) by striking the period at the end and inserting the following: "; and shall amend such waiver to permit the State to expand such demonstration project to other counties if the amount of medical assistance provided under title XIX of such Act after such expansion will not exceed the amount of medical assistance provided under such title had the project not been expanded to other counties."

SEC. 4734. TREATMENT OF CERTAIN COUNTY-OPERATED HEALTH INSURING ORGANIZATIONS.

Section 9517(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended—

(1) in paragraph (2)(A), by inserting "and in paragraph (3)" after "subparagraph (B)", and

(2) by adding at the end the following new paragraph:

"(3)(A) Subject to subparagraph (C), in the case of up to 3 health insuring organizations which are described in subparagraph (B), which first become operational on or after January 1, 1986, and which are designated by the Governor, and approved by the Legislature, of California, the amendments made by paragraph (1) shall not apply.

"(B) A health insuring organization described in this subparagraph is one that—

"(i) is operated directly by a public entity established by a county government in the State of California under a State enabling statute;

"(ii) enrolls all medicaid beneficiaries residing in the county in which it operates;

"(iii) meets the requirements for health maintenance organizations under the Knox-Keene Act (Cal. Health and Safety Code, section 1340 et seq.) and the Waxman-Duffy Act (Cal. Welfare and Institutions Code, section 14450 et seq.);

"(iv) assures a reasonable choice of providers, which includes providers that have historically served medicaid beneficiaries and which does not impose any restriction which substantially

impairs access to covered services of adequate quality where medically necessary;

"(v) provides for a payment adjustment for a disproportionate share hospital (as defined under State law consistent with section 1923 of the Social Security Act) in a manner consistent with the requirements of such section; and

"(vi) provides for payment, in the case of childrens' hospital services provided to medicaid beneficiaries who are under 21 years of age, who are children with special health care needs under title V of the Social Security Act, and who are receiving care coordination services under such title, at rates determined by the California Medical Assistance Commission.

"(C) Subparagraph (A) shall not apply with respect to any period for which the Secretary of Health and Human Services determines that the number of medicaid beneficiaries enrolled with health insuring organizations described in subparagraph (B) exceeds 10 percent of the number of such beneficiaries in the State of California.

"(D) In this paragraph, the term 'medicaid beneficiary' means an individual who is entitled to medical assistance under the State plan under title XIX of the Social Security Act, other than a qualified medicare beneficiary who is only entitled to such assistance because of section 1902(a)(10)(E) of such title."

Subpart D—Demonstration Projects and Home and Community-Based Waivers

SEC. 4741. HOME AND COMMUNITY-BASED WAIVERS.

(a) **TREATMENT OF ROOM AND BOARD.**—(1) Subsections (c)(1) and (d)(1) of section 1915 (42 U.S.C. 1396n) are each amended by adding at the end the following: "For purposes of this subsection, the term 'room and board' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded."

(b) **ADJUSTMENT TO 1915(d) CEILING TO TAKE INTO ACCOUNT THE ADDED COSTS OF OBRA 87.**—Section 1915(d)(5)(B)(iv) (42 U.S.C. 1396n(d)(5)(B)(iv)) is amended by striking "this title" the first place it appears and inserting "this title whose provisions become effective on or after such date".

SEC. 4742. TIMELY PAYMENT UNDER WAIVERS OF FREEDOM OF CHOICE OF HOSPITAL SERVICES.

(a) **IN GENERAL.**—Section 1915(b)(4) (42 U.S.C. 1396n(b)(4)) is amended by inserting before the period at the end the following: "and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1902(a)(37)(A)".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect as of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act.

(c) TREATMENT OF PERSONS WITH MENTAL RETARDATION OR A RELATED CONDITION IN A DECERTIFIED FACILITY.—

(1) **IN GENERAL.**—Section 1915(c)(7) (42 U.S.C. 1396n(c)(7)) is amended by adding at the end the following new subparagraph:

“(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981, but shall only apply to facilities the participation of which under a State plan under title XIX of the Social Security Act is terminated on or after the date of the enactment of this Act.

(d) SCOPE OF RESPITE CARE.—

(1) **IN GENERAL.**—Section 1915(c)(4) is amended by adding at the end the following:

“Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981.

(e) **PERMITTING ADJUSTMENT IN ESTIMATES TO TAKE INTO ACCOUNT PREADMISSION SCREENING REQUIREMENT.**—In the case of a waiver under section 1915(c) of the Social Security Act for individuals with mental retardation or a related condition in a State, the Secretary of Health and Human Services shall permit the State to adjust the estimate of average per capita expenditures submitted under paragraph (2)(D) of such section, with respect to such expenditures made on or after January 1, 1989, to take into account increases in expenditures for, or utilization of, intermediate care facilities for the mentally retarded resulting from implementation of section 1919(e)(7)(A) of such Act.

SEC. 4744. PROVISIONS RELATING TO FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.

(a) **EXPANSION OF WAIVERS.**—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 is amended—

(1) in paragraph (1), by striking “10” and inserting “15”; and

(2) by adding at the end the following new paragraph:

“(3) In the case of an organization receiving an initial waiver under this subsection on or after October 1, 1990, the Secretary (at the request of the organization) shall not require the organization to provide services under title XVIII of the Social Security Act on a capitated or other risk basis during the first 2 years of the waiver.”.

(b) **APPLICATION OF SPOUSAL IMPOVERISHMENT RULES.**—(1) Section 1924(a) (42 U.S.C. 1396r-5(a)) is amended by adding at the end the following new paragraph:

"(5) APPLICATION TO INDIVIDUALS RECEIVING SERVICES FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS.—This section applies to individuals receiving institutional or noninstitutional services from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986."

(2) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) Section 1924 of the Social Security Act shall apply to any individual receiving services from an organization receiving a waiver under this subsection."

SEC. 4745. DEMONSTRATION PROJECTS TO STUDY THE EFFECT OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE TO CERTAIN LOW-INCOME FAMILIES NOT OTHERWISE QUALIFIED TO RECEIVE MEDICAID BENEFITS.

(a) DEMONSTRATION PROJECTS.—

(1) **IN GENERAL.**—(A) The Secretary of Health and Human Services (hereafter in this section referred to as the "Secretary") shall enter into agreements with 3 and no more than 4 States submitting applications under this section for the purpose of conducting demonstration projects to study the effect on access to, and costs of, health care of eliminating the categorical eligibility requirement for medicaid benefits for certain low-income individuals.

(B) In entering into agreements with States under this section the Secretary shall provide that at least 1 and no more than 2 of the projects are conducted on a substate basis.

(2) **REQUIREMENTS.**—(A) The Secretary may not enter into an agreement with a State to conduct a project unless the Secretary determines that—

(i) the project can reasonably be expected to improve access to health insurance coverage for the uninsured;

(ii) with respect to projects for which the statewide requirement has not been waived, the State provides, under its plan under title XIX of the Social Security Act, for eligibility for medical assistance for all individuals described in subparagraphs (A), (B), (C), and (D) of paragraph (1) of section 1902(1) of such Act (based on the State's election of certain eligibility options the highest income standards and, based on the State's waiver of the application of any resource standard);

(iii) eligibility for benefits under the project is limited to individuals in families with income below 150 percent of the income official poverty line and who are not individuals receiving benefits under title XIX of the Social Security Act;

(iv) if the Secretary determines that it is cost-effective for the project to utilize employer coverage (as described in section 1925(b)(4)(D) of the Social Security Act), the project must require an employer contribution and benefits under the State plan under title XIX of such Act will continue to be made available to the extent they are not available under the employer coverage;

(v) the project provides for coverage of benefits consistent with subsection (b); and

(vi) the project only imposes premiums, coinsurance, and other cost-sharing consistent with subsection (c).

(B) The Secretary may waive the requirements of clause (ii) of this paragraph with respect to those projects described in subparagraph (B) of paragraph (1).

(3) **PERMISSIBLE RESTRICTIONS.**—A project may limit eligibility to individuals whose assets are valued below a level specified by the State. For this purpose, any evaluation of such assets shall be made in a manner consistent with the standards for valuation of assets under the State plan under title XIX of the Social Security Act for individuals entitled to assistance under part A of title IV of such Act. Nothing in this section shall be construed as requiring a State to provide for eligibility for individuals for months before the month in which such eligibility is first established.

(4) **EXTENSION OF ELIGIBILITY.**—A project may provide for extension of eligibility for medical assistance for individuals covered under the project in a manner similar to that provided under section 1925 of the Social Security Act to certain families receiving aid pursuant to a plan of the State approved under part A of title IV of such Act.

(5) **WAIVER OF REQUIREMENTS.**—

(A) **IN GENERAL.**—Subject to subparagraph (B), the Secretary may waive such requirements of title XIX of the Social Security Act (except section 1903(m) of the Social Security Act) as may be required to provide for additional coverage of individuals under projects under this section.

(B) **NONWAIVABLE PROVISIONS.**—Except with respect to those projects described in subparagraph (B) of paragraph (1), the Secretary may not waive, under subparagraph (A), the statewideness requirement of section 1902(a)(1) of the Social Security Act or the Federal medical assistance percentage specified in section 1905(b) of such Act.

(b) **BENEFITS.**—

(1) **IN GENERAL.**—Except as provided in this subsection, the amount, duration, and scope of medical assistance made available under a project shall be the same as the amount, duration, and scope of such assistance made available to individuals entitled to medical assistance under the State plan under section 1902(a)(10)(A)(i) of the Social Security Act.

(2) **LIMITS ON BENEFITS.**—

(A) **REQUIRED.**—Except with respect to those projects described in subparagraph (B) of paragraph (1), no medical assistance shall be made available under a project for nursing facility services or community-based long-term care services (as defined by the Secretary) or for pregnancy-related services. No medical assistance shall be made available under a project to individuals confined to a State correctional facility, county jail, local or county detention center, or other State institution.

(B) **PERMISSIBLE.**—A State, with the approval of the Secretary, may limit or otherwise deny eligibility for medical

assistance under the project and may limit coverage of items and services under the project, other than early and periodic screening, diagnostic, and treatment services for children under 18 years of age.

(3) *USE OF UTILIZATION CONTROLS.*—Nothing in this subsection shall be construed as limiting a State's authority to impose controls over utilization of services, including preadmission requirements, managed care provisions, use of preferred providers, and use of second opinions before surgical procedures.

(c) *PREMIUMS AND COST-SHARING.*—

(1) *NONE FOR THOSE WITH INCOME BELOW THE POVERTY LINE.*—Under a project, there shall be no premiums, coinsurance, or other cost-sharing for individuals whose family income level does not exceed 100 percent of the income official poverty line (as defined in subsection (g)(1)) applicable to a family of the size involved.

(2) *LIMIT FOR THOSE WITH INCOME ABOVE THE POVERTY LINE.*—Under a project, for individuals whose family income level exceeds 100 percent, but is less than 150 percent, of the income official poverty line applicable to a family of the size involved, the monthly average amount of premiums, coinsurance, and other cost-sharing for covered items and services shall not exceed 3 percent of the family's average gross monthly earnings.

(3) *INCOME DETERMINATION.*—Each project shall provide for determinations of income in a manner consistent with the methodology used for determinations of income under title XIX of the Social Security Act for individuals entitled to benefits under part A of title IV of such Act.

(d) *DURATION.*—Each project under this section shall commence not later than July 1, 1991 and shall be conducted for a 3-year period; except that the Secretary may terminate such a project if the Secretary determines that the project is not in substantial compliance with the requirements of this section.

(e) *LIMITS ON EXPENDITURES AND FUNDING.*—

(1) *IN GENERAL.*—(A) The Secretary in conducting projects shall limit the total amount of the Federal share of benefits paid and expenses incurred under title XIX of the Social Security Act to no more than \$12,000,000 in each of fiscal years 1991, 1992, and 1993, and to no more than \$4,000,000 in fiscal year 1994.

(B) Of the amounts appropriated under subparagraph (A), the Secretary shall provide that no more than one-third of such amounts shall be used to carry out the projects described in paragraph (1)(B) of subsection (a) (for which the statewide requirement has been waived).

(2) *NO FUNDING OF CURRENT BENEFICIARIES.*—No funding shall be available under a project with respect to medical assistance provided to individuals who are otherwise eligible for medical assistance under the plan without regard to the project.

(3) *NO INCREASE IN FEDERAL MEDICAL ASSISTANCE PERCENTAGE.*—Payments to a State under a project with respect to expenditures made for medical assistance made available under the project may not exceed the Federal medical assistance per-

centage (as defined in section 1905(b) of the Social Security Act) of such expenditures.

(f) **EVALUATION AND REPORT.**—

(1) **EVALUATIONS.**—For each project the Secretary shall provide for an evaluation to determine the effect of the project with respect to—

(A) access to, and costs of, health care,

(B) private health care insurance coverage, and

(C) premiums and cost-sharing.

(2) **REPORTS.**—The Secretary shall prepare and submit to Congress an interim report on the status of the projects not later than January 1, 1993, and a final report containing such summary together with such further recommendations as the Secretary may determine appropriate not later than January 1, 1995.

(g) **DEFINITIONS.**—In this section:

(1) The term “income official poverty line” means such line as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(2) The term “project” refers to a demonstration project under subsection (a).

SEC. 4746. MEDICAID RESPITE DEMONSTRATION PROJECT EXTENDED.

Section 9414 of the Omnibus Budget Reconciliation Act of 1986 is amended—

(1) by amending subsection (e) to read as follows:

“(e) **DURATION.**—The project under this section may continue until September 30, 1992.”; and

(2) in subsection (d), by striking the last sentence and inserting in lieu thereof the following new sentence: “For the period beginning October 1, 1990, and ending September 30, 1992, Federal payments for the project shall not exceed amounts expended under the project in the preceding fiscal year.”.

SEC. 4747. DEMONSTRATION PROJECT TO PROVIDE MEDICAID COVERAGE FOR HIV-POSITIVE INDIVIDUALS.

(a) **IN GENERAL.**—Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (hereafter in this section referred to as the “Secretary”) shall provide for 2 demonstration projects to be administered by States that submit an application under this section, through programs administered by the States under title XIX of the Social Security Act. Such demonstration projects shall provide coverage for the services described in subsection (c) to individuals whose income and resources do not exceed the maximum allowable amount for eligibility for any individual in any category of disability under the State plan under section 1902 of the Social Security Act, and who have tested positive for the presence of HIV virus (without regard to the presence of any symptoms of AIDS or opportunistic diseases related to AIDS).

(b) **SERVICES AVAILABLE UNDER A DEMONSTRATION PROJECT.**—(1) The medical assistance made available to individuals described in section 1902(a)(10)(A) of the Social Security Act shall be made available to individuals described in subsection (a) who receive services under a demonstration project under such paragraph.

(2) A demonstration project under subsection (a) shall provide services in addition to the services described in paragraph (1) which shall be limited only on the basis of medical necessity or the appropriateness of such services. To the extent not provided as described in paragraph (1), such additional services shall include—

(A) general and preventative medical care services (including inpatient, outpatient, residential care, physician visits, clinic visits, and hospice care);

(B) prescription drugs, including drugs for the purposes of preventative health care services;

(C) counseling and social services;

(D) substance abuse treatment services (including services for multiple substances abusers);

(E) home care services (including assistance in carrying out activities of daily living);

(F) case management;

(G) health education services;

(H) respite care for caregivers;

(I) dental services; and

(J) diagnostic and laboratory services.

(c) **AGREEMENTS WITH STATES.**—(1) Each State conducting a demonstration project under subsection (a) shall enter into an agreement with a hospital and at least one other nonprofit organization submitting applications to the State. The State shall require that such hospital and other entity have a demonstrated record of case management of patients who have tested positive for the presence of HIV virus and have access to a control group of such type of patients who are not receiving State or Federal payments for medical services (or other payments from private insurance coverage) before developing symptoms of AIDS. Under such agreement, the State shall agree to pay each such entity for the services provided under subsection (b) and not later than 12 months after the commencement of a demonstration project, institute a system of monthly payment to each such entity based on the average per capita cost of the services described in subsection (c) provided to individuals described in paragraphs (1) and (2) of subsection (a).

(2) A demonstration project described in subsection (a) shall be limited to an enrollment of not more than 200 individuals.

(3) A demonstration project conducted under subsection (a) shall commence not later than 9 months after the date of the enactment of this Act and shall terminate on the date that is 3 years after the date of commencement.

(4)(A) The Secretary shall provide for an evaluation of the comparative costs of providing services to individuals who have tested positive for the presence of HIV virus at an early stage after detection of such virus and those that are treated at a later stage after such detection.

(B) The Secretary shall report to Congress on the results of the evaluation conducted under subparagraph (A) no later than 6 months after the date of termination of the demonstration projects described in this section.

(d) **FEDERAL SHARE OF COSTS.**—The Federal share of the cost of services described in paragraph (3) furnished under a demonstration project conducted under paragraph (1) shall be determined by the

otherwise applicable Federal matching assistance percentage pursuant to section 1905(b) of the Social Security Act.

(e) **WAIVER OF REQUIREMENTS OF THE SOCIAL SECURITY ACT.**—The Secretary may waive such requirements of the Social Security Act as the Secretary determines to be necessary to carry out the purposes of this section.

(f) **LIMITATION ON AMOUNT OF EXPENDITURES.**—The amount of funds that may be expended as medical assistance to carry out the purposes of this section shall be \$5,000,000 for fiscal year 1991, \$12,000,000 for fiscal year 1992, and \$13,000,000 for fiscal year 1993.

Subpart E—Miscellaneous

SEC. 4751. REQUIREMENTS FOR ADVANCED DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE.

(a) **IN GENERAL.**—Section 1902 (42 U.S.C. 1396a(a)), as amended by sections 4401(a)(2), 4601(d), 4701(a), 4711(a), and 4722 of this title, is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (55),

(B) by striking the period at the end of paragraph (56) and inserting “; and”, and

(C) by inserting after paragraph (56) the following new paragraphs:

“(57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or health maintenance organization (as defined in section 1903(m)(1)(A)) receiving funds under the plan shall comply with the requirements of subsection (w);

“(58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of subsection (w).”; and

(2) by adding at the end the following new subsection:

“(w)(1) For purposes of subsection (a)(57) and sections 1903(m)(1)(A) and 1919(c)(2)(E), the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

“(A) to provide written information to each such individual concerning—

“(i) an individual’s rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

“(ii) the provider’s or organization’s written policies respecting the implementation of such rights;

“(B) to document in the individual’s medical record whether or not the individual has executed an advance directive;

"(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

"(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

"(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

"(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

"(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

"(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

"(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

"(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

"(E) in the case of a health maintenance organization, at the time of enrollment of the individual with the organization.

"(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive."

"(4) In this subsection, the term 'advance directive' means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(b) CONFORMING AMENDMENTS.—

(1) Section 1903(m)(1)(A)(42 U.S.C. 1396b(m)(1)(A)) is amended—

(A) by inserting "meets the requirement of section 1902(w)" after "which" the first place it appears, and

(B) by inserting "meets the requirement of section 1902(a) and" after "which" the second place it appears.

(2) Section 1919(c)(2) of such Act (42 U.S.C. 1396r(c)(2)) is amended by adding at the end the following new subparagraph:

"(E) INFORMATION RESPECTING ADVANCE DIRECTIVES.—A nursing facility must comply with the requirement of section 1902(w) (relating to maintaining written policies and procedures respecting advance directives)."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after the first day of the first month beginning more than 1 year after the date of the enactment of this Act.

(d) PUBLIC EDUCATION CAMPAIGN.—

(1) IN GENERAL.—The Secretary, no later than 6 months after the date of enactment of this section, shall develop and imple-

ment a national campaign to inform the public of the option to execute advance directives and of a patient's right to participate and direct health care decisions.

(2) *DEVELOPMENT AND DISTRIBUTION OF INFORMATION.*—The Secretary shall develop or approve nationwide informational materials that would be distributed by providers under the requirements of this section, to inform the public and the medical and legal profession of each person's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

(3) *PROVIDING ASSISTANCE TO STATES.*—The Secretary shall assist appropriate State agencies, associations, or other private entities in developing the State-specific documents that would be distributed by providers under the requirements of this section. The Secretary shall further assist appropriate State agencies, associations, or other private entities in ensuring that providers are provided a copy of the documents that are to be distributed under the requirements of the section.

(4) *DUTIES OF SECRETARY.*—The Secretary shall mail information to Social Security recipients, add a page to the medicare handbook with respect to the provisions of this section.

SEC. 4752. IMPROVEMENT IN QUALITY OF PHYSICIAN SERVICES.

(a) USE OF UNIQUE PHYSICIAN IDENTIFIERS.—

(1) ESTABLISHMENT OF SYSTEM.—

(A) *IN GENERAL.*—Section 1902 (42 U.S.C. 1396a) as amended by sections 4601(d), 4701(a), 4711(a), 4722(a), and 4751(a) is further amended by adding at the end the following new subsection:

“(x) The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this title.”

(B) *DEADLINE AND CONSIDERATIONS.*—The system established under the amendment made by subparagraph (A) may be the same as, or different from, the system established under section 9202(g) of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(2) REQUIRING INCLUSION WITH CLAIMS.—Section 1903(i) (42 U.S.C. 1396b(i)), as amended by this title, is amended—

(A) by striking the period at the end of paragraph (11) and inserting “; or”, and

(B) by inserting after paragraph (11) the following new paragraph:

“(12) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x), unless the claim for the services includes the unique physician identifier provided under such system.”

(b) MAINTENANCE OF ENCOUNTER DATA BY HEALTH MAINTENANCE ORGANIZATIONS.—

(1) *IN GENERAL.*—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)), as amended by this title, is amended—

(A) by striking “and” at the end of clause (ix),

(B) by striking the period at the end of clause (x) and inserting “; and”, and

(C) by adding at the end the following new clause:

“(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients.”.

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply to contract years beginning after the date of the establishment of the system described in section 1902(x) of the Social Security Act.

(c) *MAINTENANCE OF LIST OF PHYSICIANS BY STATES.*—

(1) *IN GENERAL.*—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by this title, is further amended—

(A) by striking “and” at the end of paragraph (56),

(B) by striking the period at the end of paragraph (57) and inserting “; and”, and

(C) by inserting after paragraph (57) the following new paragraph:

“(58) maintain a list (updated not less often than monthly, and containing each physician’s unique identifier provided under the system established under subsection (v)) of all physicians who are certified to participate under the State plan.”.

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply to medical assistance for calendar quarters beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x) of the Social Security Act.

(d) *FOREIGN MEDICAL GRADUATE CERTIFICATION.*—

(1) *PASSAGE OF FMGEMS EXAMINATION IN ORDER TO OBTAIN IDENTIFIER.*—The Secretary of Health and Human Service shall provide, in the identifier system established under section 1902(x) of the Social Security Act, that no foreign medical graduate (as defined in section 1886(h)(5)(D) of such Act) shall be issued an identifier under such system unless the individual—

(A) has passed the FMGEMS examination (as defined in section 1886(h)(5)(E) of such Act);

(B) has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates; or

(C) has held a license from 1 or more States continuously since 1958.

(2) *EFFECTIVE DATE.*—Paragraph (1) shall apply with respect to issuance of an identifier applicable to services furnished on or after January 1, 1992.

(e) *MINIMUM QUALIFICATIONS FOR BILLING FOR PHYSICIANS’ SERVICES TO CHILDREN AND PREGNANT WOMEN.*—Section 1903(i) (42 U.S.C. 1396b(i)), as amended by this title and subsection (a)(2) of this section, is further amended—

(1) by striking the period at the end of paragraph (13) and inserting “; or”; and

(2) by inserting after paragraph (13) the following new paragraph:

"(14) with respect to any amount expended for physicians' services furnished by a physician on or after January 1, 1992, to—

"(A) a child under 21 years of age, unless the physician—

"(i) is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics,

"(ii) is employed by, or affiliated with, a Federally-qualified health center (as defined in section 1905(l)(2)(B)),

"(iii) holds admitting privileges at a hospital participating in a State plan approved under this title,

"(iv) is a member of the National Health Service Corps,

"(v) documents a current, formal, consultation and referral arrangement with a pediatrician or family practitioner who has the certification described in clause (i) for purposes of specialized treatment and admission to a hospital, or

"(vi) has been certified by the Secretary as qualified to provide physicians' services to a child under 21 years of age; or

"(B) to a pregnant woman (or during the 60 day period beginning on the date of termination of the pregnancy) unless the physician—

"(i) is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics,

"(ii) is employed by, or affiliated with, a Federally-qualified health center (as defined in section 1905(l)(2)(B)),

"(iii) holds admitting privileges at a hospital participating in a State plan approved under this title,

"(iv) is a member of the National Health Service Corps,

"(v) documents a current, formal, consultation and referral arrangement with an obstetrician or family practitioner who has the certification described in clause (i) for purposes of specialized treatment and admission to a hospital, or

"(vi) has been certified by the Secretary as qualified to provide physicians' services to pregnant women."

(f) REPORTING OF MISCONDUCT OR SUBSTANDARD CARE.—

(1) IN GENERAL.—Section 1921(a) (42 U.S.C. 1396r-2(a)) is amended—

(A) in paragraph (1), in the matter before subparagraph (A), by inserting "(or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners)" after "health care practitioners"; and

(B) in paragraph (1), by adding at the end the following new subparagraph:

"(D) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity."

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to State information reporting systems as of January 1, 1992, without regard to whether or not the Secretary of Health and Human Services has promulgated any regulations to carry out such amendments by such date.

SEC. 4753. CLARIFICATION OF AUTHORITY OF INSPECTOR GENERAL.

Section 1128A(j) (42 U.S.C. 1320a-7a(j)) is amended—

(1) by striking "(j)" and inserting "(j)(1)"; and

(2) by adding at the end the following new paragraph:

"(2) The Secretary may delegate authority granted under this section and under section 1128 to the Inspector General of the Department of Health and Human Services."

SEC. 4754. NOTICE TO STATE MEDICAL BOARDS WHEN ADVERSE ACTIONS TAKEN.

(a) **IN GENERAL.**—Section 1902(a)(41) (42 U.S.C. 1396a(a)(41)) is amended by inserting "and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board" after "shall promptly notify the Secretary".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to sanctions effected more than 60 days after the date of the enactment of this Act.

SEC. 4755. MISCELLANEOUS PROVISIONS.

(a) **PSYCHIATRIC HOSPITALS.**—

(1) **CLARIFICATION OF COVERAGE OF INPATIENT PSYCHIATRIC HOSPITAL SERVICES.**—

(A) **IN GENERAL.**—Section 1905(h)(1)(A) (42 U.S.C. 1396d(h)(1)(A)), as amended by section 2340(b) of the Deficit Reduction Act of 1984, is amended by inserting "or in another inpatient setting that the Secretary has specified in regulations" after "1861(f)".

(B) **EFFECTIVE DATE.**—The amendment made by subparagraph (A) shall be effective as if included in the enactment of the Deficit Reduction Act of 1984.

(2) **INTERMEDIATE SANCTIONS FOR PSYCHIATRIC HOSPITALS.**—Section 1902 (42 U.S.C. 1396a) as amended by this title is further amended by adding at the end the following new subsection:

"(y)(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1905(h)) and further finds that the hospital's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital's participation under the State plan; or

"(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital's participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual ad-

mitted to such hospital after the effective date of the finding, or both.

"(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this title—

"(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

"(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under section 1903(a) with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this title.

"(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if—

"(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

"(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

"(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable."

(b) STATE UTILIZATION REVIEW SYSTEMS.—Section 9432 of the Omnibus Budget Reconciliation Act of 1986 is amended—

(1) in subsection (a)—

(A) by inserting "(1)" after "IN GENERAL.—",

(B) by striking ", during the period" and all that follows through "Congress," and

(C) by adding at the end the following new paragraph:

"(2) The Secretary may not, during the period beginning on the date of the enactment of the Omnibus Budget Reconciliation Act of 1990 and ending on the date that is 180 days after the date on which the report required by subsection (d) is submitted to the Congress, publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act to include a program for ambulatory surgery, preadmission testing, or same-day surgery.";

(2) in subsection (b)(4), by inserting "and subsection (d)" after "In this subsection"; and

(3) by adding at the end the following new subsection:

"(d) REPORT.—The Secretary shall report to Congress, by not later than January 1, 1993, for each State in a representative sample of States—

"(1) an analysis of the procedures for which programs for ambulatory surgery, preadmission testing, and same-day surgery are appropriate for patients who are covered under the State medicaid plan, and

"(2) the effects of such programs on access of such patients to necessary care, quality of care, and costs of care.
In selecting such a sample of States, the Secretary shall include some States with medicaid plans that include such programs."

(c) **ADDITIONAL MISCELLANEOUS PROVISIONS.—**

(1) **Effective July 1, 1990—**

(A) section 1902(a)(10)(C)(iv) of the Social Security Act is amended by striking "through (20)" and inserting "through (21)", and

(B) section 1902(j) of such Act is amended by striking "through (21)" and inserting "through (22)".

(2) **Effective as if included in subtitle D of title VI of the Omnibus Budget Reconciliation Act of 1989, section 301(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331(j)) is amended by adding at the end the following:** "This paragraph does not authorize the withholding of information from either House of Congress or from, to the extent of matter within its jurisdiction, any committee or subcommittee of such committee or any joint committee of Congress or any subcommittee of such joint committee."

(3) **Section 505(b) (42 U.S.C. 705(b)) is amended in the matter preceding paragraph (1) by striking "requirement" and inserting "requirements".**

PART 5—PROVISIONS RELATING TO NURSING HOME REFORM

SEC. 4801. TECHNICAL CORRECTIONS RELATING TO NURSING HOME REFORM.

(a) **NURSE AIDE TRAINING AND COMPETENCY EVALUATION.—**

(1) **NO COMPLIANCE ACTIONS BEFORE EFFECTIVE DATE OF GUIDELINES.—**The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act on the basis of the State's failure to meet the requirement of section 1919(e)(1)(A) of such Act before the effective date of guidelines, issued by the Secretary, establishing requirements under section 1919(f)(2)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date.

(2) **PART-TIME NURSE AIDES NOT ALLOWED DELAY IN TRAINING.—**Section 1919(b)(5)(A) (42 U.S.C. 1396r(b)(5)(A)) is amended—

(i) by striking "A nursing facility" and inserting "(i) Except as provided in clause (ii), a nursing facility";

(ii) by striking "(on a full-time, temporary, per diem, or other basis) and inserting "on a full-time basis";

(iii) by striking "(i)" and "(ii)" and inserting "(I)" and "(II)"; and

(iv) by adding at the end the following:

"(ii) A nursing facility must not use on a temporary, per diem, leased, or on any other basis other than as a permanent employee any individual as a nurse aide in

the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i)."

(3) **REQUIREMENT TO OBTAIN INFORMATION FROM NURSE AIDE REGISTRY.**—Section 1919(b)(5)(C) (42 U.S.C. 1396r(b)(5)(C)) is amended by striking "the State registry established under subsection (e)(2)(A) as to information in the registry" and inserting "any State registry established under subsection (e)(2)(A) that the facility believes will include information".

(4) **RETRAINING OF NURSE AIDES.**—Section 1919(b)(5)(D) (42 U.S.C. 1396r(b)(5)(D)) is amended by striking the period at the end and inserting "; or a new competency evaluation program."

(5) **CLARIFICATION OF NURSE AIDES NOT SUBJECT TO CHARGES.**—Section 1919(f)(2)(A)(iv) (42 U.S.C. 1396r(f)(2)(A)(iv)) is amended—

(A) in subclause (I), by striking "and" at the end;

(B) in subclause (II), by inserting after "nurse aide" the following: "who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program";

(C) in subclause (II), by striking the period at the end and inserting ", and"; and

(D) by adding at the end the following new subclause:

"(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a pro rata basis during the period in which the nurse aide is so employed."

(6) **MODIFICATION OF NURSING FACILITY DEFICIENCY STANDARDS.**—

(A) **IN GENERAL.**—Section 1919(f)(2)(B)(iii)(I) (42 U.S.C. 1396r(f)(2)(B)(iii)(I)) is amended to read as follows:

"(I) offered by or in a nursing facility which, within the previous 2 years—

"(a) has operated under a waiver under subsection (b)(4)(C)(ii) that was granted on the basis of a demonstration that the facility is unable to provide the nursing care required under subsection (b)(4)(C)(i) for a period in excess of 48 hours during a week;

"(b) has been subject to an extended (or partial extended) survey under section 1819(g)(2)(B)(i) or subsection (g)(2)(B)(i); or

"(c) has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) or subsection (h)(2)(A)(ii) of not less than \$5,000, or has been subject to a remedy described in subsection (h)(1)(B)(i), clause (i), (iii), or (iv) of subsection (h)(2)(A), clause (i) or (iii) of section 1819(h)(2)(B), or section 1819(h)(4), or";

(B) **EFFECTIVE DATE.**—The amendments made by subparagraph (A) shall take effect as if included in the enact-

ment of the Omnibus Budget Reconciliation Act of 1987, except that a State may not approve a training and competency evaluation program or a competency evaluation program offered by or in a nursing facility which, pursuant to any Federal or State law within the 2-year period beginning on October 1, 1988—

(i) had its participation terminated under title XVIII of the Social Security Act or under the State plan under title XIX of such Act;

(ii) was subject to a denial of payment under either such title;

(iii) was assessed a civil money penalty not less than \$5,000 for deficiencies in nursing facility standards;

(iv) operated under a temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

(v) pursuant to State action, was closed or had its residents transferred.

(7) **CLARIFICATION OF STATE RESPONSIBILITY TO DETERMINE COMPETENCY.**—Section 1919(f)(2)(B) (42 U.S.C. 1396r(f)(2)(B)) is amended in the second sentence by inserting “(through subcontract or otherwise)” after “may not delegate”.

(8) **EXTENSION OF ENHANCED MATCH RATE UNTIL OCTOBER 1, 1990.**—Section 1903(a)(2)(B) (42 U.S.C. 1396b(a)(2)(B)) is amended by striking “July 1, 1990” and inserting “October 1, 1990”.

(9) **EFFECTIVE DATE.**—Except as provided in paragraph (6), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(b) **PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW.**—

(1) **NO COMPLIANCE ACTIONS BEFORE EFFECTIVE DATE OF GUIDELINES.**—The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 or section 1919(e)(7)(D) of the Social Security Act on the basis of the State's failure to meet the requirement of section 1919(e)(7)(A) of such Act before the effective date of guidelines, issued by the Secretary, establishing minimum criteria under section 1919(f)(8)(A) of such Act, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirement before such effective date.

(2) **CLARIFICATION WITH RESPECT TO ADMISSIONS AND READMISSION FROM A HOSPITAL.**—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) in subsection (b)(3)(F), by striking “A nursing facility” and by inserting “Except as provided in clauses (ii) and (iii) of subsection (e)(7)(A), a nursing facility”; and

(B) in subsection (e)(7)(A)—

(i) by redesignating the first 2 sentences as clause (i) with the following heading (and appropriate indentation):

“(i) **IN GENERAL.**—”, and

(ii) by adding at the end the following:

"(ii) **CLARIFICATION WITH RESPECT TO CERTAIN READMISSIONS.**—The preadmission screening program under clause (i) need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

"(iii) **EXCEPTION FOR CERTAIN HOSPITAL DISCHARGES.**—The preadmission screening program under clause (i) shall not apply to the admission to a nursing facility of an individual—

"(I) who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

"(II) who requires nursing facility services for the condition for which the individual received care in the hospital, and

"(III) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services."

(3) **DENIAL OF PAYMENTS FOR CERTAIN RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES.**—Section 1919(e)(7) (42 U.S.C. 1395r(e)(7)) is amended—

(A) in subparagraph (D)—

(i) in the heading, by striking "WHERE FAILURE TO CONDUCT PREADMISSION SCREENING",

(ii) by designating the first sentence as clause (i) with the following heading (and appropriate indentation):

"(i) **FOR FAILURE TO CONDUCT PREADMISSION SCREENING OR ANNUAL REVIEW.**—", and

(iii) by adding at the end the following new clause:

"(ii) **FOR CERTAIN RESIDENTS NOT REQUIRING NURSING FACILITY LEVEL OF SERVICES.**—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual (other than an individual described in subparagraph (C)(i)) who does not require the level of services provided by a nursing facility."; and

(B) in subparagraph (E), by striking "the requirement of this paragraph" and inserting "the requirements of subparagraphs (A) through (C) of this paragraph".

(4) **NO DELEGATION OF AUTHORITY TO CONDUCT SCREENING AND REVIEWS.**—Section 1919 is further amended—

(A) in subsection (b)(3)(F), by adding at the end the following:

"A State mental health authority and a State mental retardation or developmental disability authority may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility)."; and

(B) in subsection (e)(7)(B), by adding at the end the following new clause:

“(iv) *PROHIBITION OF DELEGATION.*—A State mental health authority, a State mental retardation or developmental disability authority, and a State may not delegate (by subcontract or otherwise) their responsibilities under this subparagraph to a nursing facility (or to an entity that has a direct or indirect affiliation or relationship with such a facility).”.

(5) *ANNUAL REPORTS.*—

(A) *STATE REPORTS.*—Section 1919(e)(7)(C) (42 U.S.C. 1396r(e)(7)(C)) is amended by adding at the end the following new clause:

“(iv) *ANNUAL REPORT.*—Each State shall report to the Secretary annually concerning the number and disposition of residents described in each of clauses (ii) and (iii).”.

(B) *SECRETARIAL REPORT.*—Section 4215 of the Omnibus Budget Reconciliation Act of 1987 is amended by adding at the end the following new sentence: “Each such report shall also include a summary of the information reported by States under section 1919(e)(7)(C)(iv) of such Act.”.

(6) *REVISION OF ALTERNATIVE DISPOSITION PLANS.*—Section 1919(e)(7)(E) (42 U.S.C. 1396r(e)(7)(E)) is amended by adding at the end the following: “The State may revise such an agreement, subject to the approval of the Secretary, before October 1, 1991, but only if, under the revised agreement, all residents subject to the agreement who do not require the level of services of such a facility are discharged from the facility by not later than April 1, 1994.”.

(7) *DEFINITION OF MENTALLY ILL.*—Section 1919(e)(7)(G)(i) (42 U.S.C. 1396r(e)(7)(G)(i)) is amended—

(A) by striking “primary or secondary” and all that follows through “3rd edition)” and inserting “serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health)”;

(B) by inserting before the period “or a diagnosis (other than a primary diagnosis) of dementia and a primary diagnosis that is not a serious mental illness”.

(8) *SUBSTITUTION OF “SPECIALIZED SERVICES” FOR “ACTIVE TREATMENT”.*—Sections 1919(b)(3)(F) and 1919(e)(7) (42 U.S.C. 1396r(b)(3)(F), 1396r(e)(7)) are each amended by striking “active treatment” and “ACTIVE TREATMENT” each place either appears and inserting “specialized services” and “SPECIALIZED SERVICES”, respectively.

(9) *EFFECTIVE DATES.*—

(A) *IN GENERAL.*—Except as provided in subparagraph (B), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

(B) *EXCEPTION.*—The amendments made by paragraphs (4), (6), and (8) shall take effect on the date of the enactment of this Act, without regard to whether or not regulations to implement such amendments have been promulgated.

(c) **ENFORCEMENT PROCESS.**—*The Secretary of Health and Human Services shall not take (and shall not continue) any action against a State under section 1904 of the Social Security Act on the basis of the State's failure to meet the requirements of section 1919(h)(2) of such Act before the effective date of guidelines, issued by the Secretary, regarding the establishment of remedies by the State under such section, if the State demonstrates to the satisfaction of the Secretary that it has made a good faith effort to meet such requirements before such effective date.*

(d) **SUPERVISION OF HEALTH CARE OF RESIDENTS OF NURSING FACILITIES BY NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS ACTING IN COLLABORATION WITH PHYSICIANS.**—

(1) **IN GENERAL.**—*Section 1919(b)(6)(A) (42 U.S.C. 1396r(b)(6)(A)) is amended by inserting "(or, at the option of a State, under the supervision of a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician)" after "physician".*

(2) **EFFECTIVE DATE.**—*The amendment made by paragraph (1) applies with respect to nursing facility services furnished on or after October 1, 1990, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.*

(e) **OTHER AMENDMENTS.**—

(1) **ASSURANCE OF APPROPRIATE PAYMENT AMOUNTS.**—

(A) **IN GENERAL.**—*Section 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)) is amended by inserting "(including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title)" after "take into account the costs".*

(B) **DETAILS IN PLAN AMENDMENT.**—*Section 4211(b)(2) of the Omnibus Budget Reconciliation Act of 1987 is amended by inserting after the first sentence the following: "Each such amendment shall include a detailed description of the specific methodology to be used in determining the appropriate adjustment in payment amounts for nursing facility services."*

(2) **DISCLOSURE OF INFORMATION OF QUALITY ASSESSMENT AND ASSURANCE COMMITTEES.**—*Section 1919(b)(1)(B) (42 U.S.C. 1396r(b)(1)(B)) is amended by adding at the end the following new sentence: "A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph."*

(3) **PERIOD FOR RESIDENT ASSESSMENT.**—*Section 1919(b)(3)(C)(i)(I) (42 U.S.C. 1396r(b)(3)(C)(i)(I)) is amended by striking "4 days" and inserting "not to exceed 14 days".*

(4) **CLARIFICATION OF RESPONSIBILITY FOR SERVICES FOR MENTALLY ILL AND MENTALLY RETARDED RESIDENTS.**—*Section 1919(b)(4)(A) (42 U.S.C. 1396r(b)(4)(A)) is amended—*

(A) *by striking "and" at the end of clause (v),*

(B) by striking the period at the end of clause (vi) and inserting “; and” and

(C) by inserting after clause (vi) the following new clause:
 “(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.”

(5) **CLARIFICATION OF EXTENT OF STATE WAIVER AUTHORITY; NOTIFICATION OF WAIVERS.**—Section 1919(b)(4)(C)(ii) (42 U.S.C. 1396r(b)(4)(C)(ii)) is amended—

(A) by striking “A State” and all that follows through “a facility if” and inserting “To the extent that a facility is unable to meet the requirements of clause (i), a State may waive such requirements with respect to the facility if”;

(B) by striking “and” at the end of subclause (II);

(C) by striking the period at the end of subclause (III) and inserting a comma; and

(D) by adding at the end the following new subclauses:

“(IV) the State agency granting a waiver of such requirements provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

“(V) the nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.”

(6) **CLARIFICATION OF DEFINITION OF NURSE AIDE.**—Section 1919(b)(5)(F)(i) (42 U.S.C. 1396r(b)(5)(F)(i)) is amended by striking “(G)),” and inserting “(G)) or a registered dietician,”

(7) **CHARGES APPLICABLE IN CASES OF CERTAIN MEDICAID-ELIGIBLE INDIVIDUALS.**—

(A) **IN GENERAL.**—Section 1919(c) (42 U.S.C. 1396r(c)) is amended—

(i) by redesignating paragraph (7) as paragraph (8); and

(ii) by inserting after paragraph (6) the following new paragraph:

“(7) **LIMITATION ON CHARGES IN CASE OF MEDICAID-ELIGIBLE INDIVIDUALS.**—

“(A) **IN GENERAL.**—A nursing facility may not impose charges, for certain medicaid-eligible individuals for nursing facility services covered by the State under its plan under this title, that exceed the payment amounts established by the State for such services under this title.

“(B) **CERTAIN MEDICAID INDIVIDUALS DEFINED.**—In subparagraph (A), the term ‘certain medicaid-eligible individual’ means an individual who is entitled to medical assistance for nursing facility services in the facility under this title but with respect to whom such benefits are not being paid because, in determining the amount of the individ-

ual's income to be applied monthly to payment for the costs of such services, the amount of such income exceeds the payment amounts established by the State for such services under this title."

(B) **EFFECTIVE DATE.**—The amendments made by subparagraph (A) shall take effect on the date of the enactment of this Act, without regard to whether or not regulations to implement such amendments have been promulgated.

(8) **RESIDENTS' RIGHTS TO REFUSE INTRA-FACILITY TRANSFERS TO MOVE THE RESIDENT TO A MEDICARE-QUALIFIED PORTION.**—Section 1919(c)(1)(A) (42 U.S.C. 1396r(c)(1)(A)) is amended—

(A) by redesignating clause (x) as clause (xi) and by inserting after clause (ix) the following new clause:

"(x) **REFUSAL OF CERTAIN TRANSFERS.**—The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of title XVIII) to a portion of the facility that is such a skilled nursing facility."; and

(B) by adding at the end the following: "A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resident's eligibility or entitlement to medical assistance under this title or a State's entitlement to Federal medical assistance under this title with respect to services furnished to such a resident.".

(9) **RESIDENT ACCESS TO CLINICAL RECORDS.**—Section 1919(c)(1)(A)(iv) (42 U.S.C. 1396r(c)(1)(A)(iv)) is amended by inserting before the period at the end the following: "and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request".

(10) **INCLUSION OF STATE NOTICE OF RIGHTS IN FACILITY NOTICE OF RIGHTS.**—Section 1919(c)(1)(B)(ii) (42 U.S.C. 1396r(c)(1)(B)(ii)) is amended by inserting "including the notice (if any) of the State developed under subsection (e)(6)" after "in such rights)".

(11) **REMOVAL OF DUPLICATIVE REQUIREMENT FOR QUALIFICATIONS OF NURSING HOME ADMINISTRATORS.**—Effective on the date on which the Secretary promulgates standards regarding the qualifications of nursing facility administrators under section 1919(f)(4) of the Social Security Act—

(A) paragraph (29) of section 1902(a) of such Act (42 U.S.C. 1396a(a)) is repealed; and

(B) section 1908 of such Act (42 U.S.C. 1396g) is repealed.

(12) **CLARIFICATION OF NURSE AIDE REGISTRY REQUIREMENTS.**—Section 1919(e)(2) (42 U.S.C. 1396r(e)(2)) is amended—

(A) in subparagraph (A), by striking the period and inserting the following: "; or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989."; and

(B) by adding at the end the following new subparagraph:

"(C) PROHIBITION AGAINST CHARGES.—A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A)."

(13) CLARIFICATION ON FINDINGS OF NEGLECT.—Section 1919(g)(1)(C) (42 U.S.C. 1396r(g)(1)(C)) is amended by adding at the end the following: "A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual."

(14) TIMING OF PUBLIC DISCLOSURE OF SURVEY RESULTS.—Section 1919(g)(5)(A)(i) (42 U.S.C. 1396r(g)(5)(A)(i)) is amended by striking "deficiencies and plans" and inserting "deficiencies, within 14 calendar days after such information is made available to those facilities, and approved plans".

(15) OMBUDSMAN PROGRAM COORDINATION WITH STATE SURVEY AND CERTIFICATION AGENCIES.—Section 1919(g)(5)(B) (42 U.S.C. 1396r(g)(5)(B)) is amended by striking "with respect" and inserting "or of any adverse action taken against a nursing facility under paragraphs (1), (2), or (3) of subsection (h), with respect".

(16) DENIAL OF PAYMENT OF LEGAL FEES FOR FRIVOLOUS LITIGATION.—

(A) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)), [as amended by section X??? (a)(1)(B) of this Act], is amended—

(i) by striking "or" at the end of paragraph (9);

(ii) by striking the period at the end of paragraph (10) and inserting "; or"; and

(iii) by inserting after paragraph (10) the following new paragraph:

"(11) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action."

(B) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply with respect to actions initiated on or after the date of the enactment of this Act.

(17) PROVISIONS RELATING TO STAFFING REQUIREMENTS.—

(A) MAINTAINING REGULATORY STANDARDS FOR CERTAIN SERVICES.—Any regulations promulgated and applied by the Secretary of Health and Human Services after the date of the enactment of the Omnibus Budget Reconciliation Act of 1987 with respect to services described in clauses (ii), (iv), and (v) of section 1919(b)(4)(A) of the Social Security Act shall include requirements for providers of such services that are at least as strict as the requirements applicable to providers of such services prior to the enactment of the Omnibus Budget Reconciliation Act of 1987.

(B) STUDY ON STAFFING REQUIREMENTS IN NURSING FACILITIES.—The Secretary shall conduct a study and report to Congress no later than January 1, 1992, on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for

skilled nursing facilities serving as providers of services under title XVIII of the Social Security Act and nursing facilities receiving payments under a State plan under title XIX of the Social Security Act, and shall include in such study recommendations regarding appropriate minimum ratios.

(18) *STATE REQUIREMENTS RELATING TO PROGRAMS.*—Amend 1919(e)(1)(A) to strike “under clause (i) or (ii) of subsection (f)(2)(A)” and insert “under subsection (f)(2)”.

(19) *EFFECTIVE DATES.*—Except as provided in paragraphs (7), (1), and (1), the amendments made by this subsection shall take effect as if they were included in the enactment of the Omnibus Budget Reconciliation Act of 1987.

TITLE V—INCOME SECURITY, HUMAN RESOURCES, AND RELATED PROGRAMS

Subtitle A—Human Resource and Family Policy Amendments

SEC. 5001. TABLE OF CONTENTS.

Sec. 5001. Table of contents.

Sec. 5002. Amendment of Social Security Act.

CHAPTER 1—CHILD SUPPORT ENFORCEMENT

Sec. 5011. Extension of IRS intercept for non-AFDC families.

Sec. 5012. Extension of Commission on Interstate Child Support.

Sec. 5013. Child support enforcement waiver.

CHAPTER 2—UNEMPLOYMENT COMPENSATION

Sec. 5021. “Reed Act” provisions made permanent.

CHAPTER 3—SUPPLEMENTAL SECURITY INCOME

Sec. 5031. Exclusion from income and resources of victims’ compensation payments.

Sec. 5032. Attainment of age 65 not to serve as basis for termination of eligibility under section 1619(b).

Sec. 5033. Exclusion from income of impairment-related work expenses.

Sec. 5034. Treatment of royalties and honoraria as earned income.

Sec. 5035. Certain State relocation assistance excluded from SSI income and resources.

Sec. 5036. Evaluation of child’s disability by pediatrician or other qualified specialist.

Sec. 5037. Reimbursement for vocational rehabilitation services furnished during certain months of nonpayment of SSI benefits.

Sec. 5038. Extension of period of presumptive eligibility for benefits.

Sec. 5039. Continuing disability or blindness reviews not required more than once annually.

Sec. 5040. Concurrent SSI and food stamp applications by institutionalized individuals.

Sec. 5041. Notification of certain individuals eligible to receive retroactive benefits.

CHAPTER 4—AID TO FAMILIES WITH DEPENDENT CHILDREN

Sec. 5051. Optional monthly reporting and retrospective budgeting.

- Sec. 5052. Children receiving foster care maintenance or adoption assistance payments not treated as member of family unit for purposes of determining eligibility for, or amount of, AFDC benefit.
- Sec. 5053. Elimination of term "legal guardian".
- Sec. 5054. Reporting of child abuse and neglect.
- Sec. 5055. Disclosure of information about AFDC applicants and recipients authorized for purposes directly connected to State foster care and adoption assistance programs.
- Sec. 5056. Repatriation.
- Sec. 5057. Technical amendment to National Commission on Children.
- Sec. 5058. Extension of prohibition against implementation of proposed regulations on emergency assistance and AFDC special needs.
- Sec. 5059. Amendments to Minnesota Family Investment Plan demonstration.
- Sec. 5060. Good cause exception to required cooperation for transitional child care benefits.
- Sec. 5061. Technical corrections regarding penalty for failure to participate in JOBS program.
- Sec. 5062. Technical corrections regarding AFDC-UP eligibility requirements.
- Sec. 5063. Family Support Act demonstration projects.
- Sec. 5064. Study of JOBS programs operated by Indian Tribes and Alaska Native organizations.

CHAPTER 5—CHILD WELFARE AND FOSTER CARE

- Sec. 5071. Accounting for administrative costs.
- Sec. 5072. Section 427 triennial reviews.
- Sec. 5073. Independent living initiatives.

CHAPTER 6—CHILD CARE

- Sec. 5081. Grants to States for child care.
- Sec. 5082. Child care and development block grant.

SEC. 502. AMENDMENT OF SOCIAL SECURITY ACT.

Except as otherwise expressly provided, wherever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

CHAPTER 1—CHILD SUPPORT ENFORCEMENT

SEC. 5011. EXTENSION OF IRS INTERCEPT FOR NON-AFDC FAMILIES.

(a) **AUTHORITY OF STATES TO REQUEST WITHHOLDING OF FEDERAL TAX REFUNDS FROM PERSONS OWING PAST DUE CHILD SUPPORT.**—Section 464(a)(2)(B) (42 U.S.C. 664(a)(2)(B)) is amended by striking “, and before January 1, 1991”.

(b) **WITHHOLDING OF FEDERAL TAX REFUNDS AND COLLECTION OF PAST DUE CHILD SUPPORT ON BEHALF OF DISABLED CHILD OF ANY AGE, AND OF SPOUSAL SUPPORT INCLUDED IN ANY CHILD SUPPORT ORDER.**—Section 464(c) (42 U.S.C. 664(c)) is amended—

(1) in paragraph (2), by striking “minor child.” and inserting “qualified child (or a qualified child and the parent with whom the child is living if the same support order includes support for the child and the parent).”; and

(2) by adding at the end the following:

“(3) For purposes of paragraph (2), the term ‘qualified child’ means a child—

“(A) who is a minor; or

“(B)(i) who, while a minor, was determined to be disabled under title II or XVI; and

"(ii) for whom an order of support is in force."

(c) **EFFECTIVE DATE.**—The amendments made by subsection (b) shall take effect on January 1, 1991.

SEC. 5012. EXTENSION OF COMMISSION ON INTERSTATE CHILD SUPPORT.

(a) **REAUTHORIZATION.**—Section 126 of the Family Support Act of 1988 (42 U.S.C. 666 note; Public Law 100-485) is amended—

(1) in subsection (d)—

(A) in paragraph (1), by striking "1990" and inserting "1991"; and

(B) in paragraph (2), by striking "1991" and inserting "1992";

(2) in subsection (e), by adding at the end the following:

"(5)(A) Individuals may be appointed to serve the Commission without regard to the provisions of title 5 that govern appointments in the competitive service, without regard to the competitive service, and without regard to the classification system in chapter 53 of title 5, United States Code. The chairman of the Commission may fix the compensation of the Executive Director at a rate that shall not exceed the maximum rate of the basic pay payable under GS-18 of the General Schedule as contained in title 5, United States Code.

"(B) The Executive Director may appoint and fix the compensation of such additional personnel as the Executive Director considers necessary to carry out the duties of the Commission. Such personnel may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates.

"(C) On the request of the chairman, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties under this section without regard to section 3341 of title 5, United States Code."; and

(3) in subsection (f)(1), by striking "1991" and inserting "1992".

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5013. CHILD SUPPORT ENFORCEMENT WAIVER.

(a) **IN GENERAL.**— The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into an agreement with the State of Texas waiving (with respect to cases where a court has issued an order for child support) the following requirements under the State plan for child and spousal support that are described in subparagraphs (A) and (B) of section 454(6) of the Social Security Act, with respect to a project, based in the county of Bexar, of delinquency monitoring for child support enforcement:

(1) The submission of a written application by an individual requesting child support collection services.

(2) The payment of an application fee with respect to an application for such services.

(b) **CONTENTS OF WAIVER AGREEMENT.**—In the agreement between the Secretary and the State of Texas described in subsection (a), the waiver granted under such agreement shall provide the following:

(1) The waiver shall apply only with respect to the provision of child support collection services.

(2) Before the provision of any child support collection services, the organizational unit designated under section 454(3) of the Social Security Act (in this section referred to as the "State agency") shall provide written notification to each custodial parent of the right of such parent to refuse such services.

(3) The State shall ensure that, to the extent possible, each parent of the child on behalf of whom such services are provided (regardless of whether such parent is a custodial parent) is to receive written notice at the time such services are provided, explaining—

(A) the legal rights of parents with respect to the child support collection services provided; and

(B) the responsibilities of the State agency in providing such child support collection services (including the monitoring of delinquent child support payments).

(4) A case record shall be deemed to have been established by the State agency upon notification of a custodial parent of the option to receive the child support enforcement services described in this subsection.

(5) Any period of enforcement by the State agency under this section with respect to the collection of delinquent child support payments shall be deemed to begin on the first day of any such delinquency.

(d) **STUDY AND REPORT.**—

(1) **STUDY REQUIRED.**—As a condition precedent to granting the waiver described in subsection (a), the State agency shall agree to conduct a study of the cost-effectiveness to the Federal Government and to the State of Texas of the monitoring of delinquent child support payments under the State plan under section 454 of the Social Security Act.

(2) **CONDUCT OF STUDY.**—

(A) **IN GENERAL.**—The study required by paragraph (1) shall be conducted in accordance with the criteria established by the Secretary in accordance with subparagraph (B).

(B) **CRITERIA.**—Not later than February 1, 1991, the Secretary shall establish the criteria required by subparagraph (A), in consultation with—

(i) 1 or more representatives of organizations representing child support administrators;

(ii) 1 or more representatives of the General Accounting Office;

(iii) 1 or more representatives of the State of Texas; and

(iv) such other individuals or organizations with experience in the evaluation of child support programs, as the Secretary may designate.

(3) **REPORT.**—Not later than 3 months after the expiration of the waiver described in subsection (a), the State agency shall

submit to the Secretary and to the Congress a report that includes the findings of the study required by this subsection.

(e) **DURATION OF WAIVER.**—The waiver described in subsection (a) shall be effective for not more than 2 years.

(f) **MATCHING PAYMENTS.**—

(1) **GENERAL EXPENDITURES.**—In lieu of any payment under section 455 of the Social Security Act with respect to expenditures of the State of Texas to carry out child support enforcement programs with respect to which the waiver described in subsection (a) applies, the Secretary shall pay the State an amount equal to the lesser of—

(A) 66 percent of such expenditures; or

(B) \$500,000.

(2) **STUDY EXPENDITURES.**—In lieu of any payment under section 455 of the Social Security Act with respect to expenditures of the State of Texas to carry out the study required by subsection (d), the Secretary shall pay the State an amount equal to 66 percent of such expenditures.

CHAPTER 2—UNEMPLOYMENT COMPENSATION

SEC. 5021. AMOUNTS TRANSFERRED TO STATE UNEMPLOYMENT COMPENSATION PROGRAM ACCOUNTS.

(a) **ALLOCATION OF AMOUNTS.**—Paragraph (2) of section 903(a) (42 U.S.C. 1103(a)(2)) is amended to read as follows:

“(2) Each State’s share of the funds to be transferred under this subsection as of any October 1—

“(A) shall be determined by the Secretary of Labor and certified by such Secretary to the Secretary of the Treasury before such date, and

“(B) shall bear the same ratio to the total amount to be so transferred as—

“(i) the amount of wages subject to tax under section 3301 of the Internal Revenue Code of 1986 during the preceding calendar year which are determined by the Secretary of Labor to be attributable to the State, bears to

“(ii) the total amount of wages subject to such tax during such year.”

(b) **USE OF TRANSFERRED AMOUNTS.**—Paragraph (2) of section 903(c) (42 U.S.C. 1103(c)(2)) is amended—

(1) by striking “and” at the end of subparagraph (C), and

(2) by striking so much of such paragraph as follows subparagraph (C) and inserting the following:

“(D)(i) the appropriation law limits the total amount which may be obligated under such appropriation at any time to an amount which does not exceed, at any such time, the amount by which—

“(I) the aggregate of the amounts transferred to the account of such State pursuant to subsections (a) and (b), exceeds

“(II) the aggregate of the amounts used by the State pursuant to this subsection and charged against the amounts transferred to the account of such State, and

"(ii) for purposes of clause (i), amounts used by a State for administration shall be chargeable against transferred amounts at the exact time the obligation is entered into, and

"(E) the use of the money is accounted for in accordance with standards established by the Secretary of Labor."

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to fiscal years beginning after the date of the enactment of this Act.

CHAPTER 3—SUPPLEMENTAL SECURITY INCOME

SEC. 5031. EXCLUSION FROM INCOME AND RESOURCES OF VICTIMS' COMPENSATION PAYMENTS.

(a) **EXCLUSION FROM INCOME.**—Section 1612(b) (42 U.S.C. 1382a(b)) is amended—

(1) by striking "and" at the end of paragraph (15);

(2) by striking the period at the end of paragraph (16) and inserting "; and"; and

(3) by adding at the end the following:

"(17) any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime."

(b) **EXCLUSION FROM RESOURCES.**—Section 1613(a) (42 U.S.C. 1382b(a)) is amended—

(1) by striking "and" at the end of paragraph (7);

(2) by striking the period at the end of paragraph (8) and inserting "; and"; and

(3) by adding at the end the following:

"(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime."

(c) **VICTIMS COMPENSATION AWARD NOT REQUIRED TO BE ACCEPTED AS CONDITION OF RECEIVING BENEFITS.**—Section 1631(a) (42 U.S.C. 1383(a)) is amended by adding at the end the following:

"(9) Benefits under this title shall not be denied to any individual solely by reason of the refusal of the individual to accept an amount offered as compensation for a crime of which the individual was a victim."

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5032. ATTAINMENT OF AGE 65 NOT TO SERVE AS BASIS FOR TERMINATION OF ELIGIBILITY UNDER SECTION 1619(b).

(a) **IN GENERAL.**—Section 1619(b)(1) (42 U.S.C. 1392h(b)(1)) is amended by striking "under age 65".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5033. EXCLUSION FROM INCOME OF IMPAIRMENT-RELATED WORK EXPENSES.

(a) **IN GENERAL.**—Section 1612(b)(4)(B)(ii) (42 U.S.C. 1382a(b)(4)(B)(ii)) is amended by striking “(for purposes of determining the amount of his or her benefits under this title and of determining his or her eligibility for such benefits for consecutive months of eligibility after the initial month of such eligibility)”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to benefits payable for calendar months beginning after the date of the enactment of this Act.

SEC. 5034. TREATMENT OF ROYALTIES AND HONORARIA AS EARNED INCOME.

(a) **IN GENERAL.**—Section 1612(a) (42 U.S.C. 1382a(a)) is amended—

(1) in paragraph (1)—

(A) by striking “and” at the end of subparagraph (C); and

(B) by adding at the end the following:

“(E) any royalty earned by an individual in connection with any publication of the work of the individual, and that portion of any honorarium which is received for services rendered; and”; and

(2) in paragraph (2)(F), by inserting “not described in paragraph (1)(E)” before the period.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to benefits for months beginning on or after the first day of the 13th calendar month following the month in which this Act is enacted.

SEC. 5035. CERTAIN STATE RELOCATION ASSISTANCE EXCLUDED FROM SSI INCOME AND RESOURCES.

(a) **EXCLUSION FROM INCOME.**—Section 1612(b) (42 U.S.C. 1382a(b)), as amended by section 5031(a) of this Act, is amended—

(1) by striking “and” at the end of paragraph (16);

(2) by striking the period at the end of paragraph (17) and inserting a semicolon; and

(3) by inserting after paragraph (17) the following:

“(18) relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act.”.

(b) **EXCLUSION FROM RESOURCES.**—Section 1613(a) (42 U.S.C. 1382b(a)), as amended by section 5031(b) of this Act, is amended—

(1) by striking “and” at the end of paragraph (8);

(2) by striking the period at the end of paragraph (9) and inserting “; and”; and

(3) by inserting after paragraph (9) the following:

“(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits for calendar months beginning in the 3-year period that begins on the first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5036. EVALUATION OF CHILD'S DISABILITY BY PEDIATRICIAN OR OTHER QUALIFIED SPECIALIST.

(a) **IN GENERAL.**—Section 1614(a)(3) (42 U.S.C. 1382c(a)(3)) is amended by adding at the end the following:

“(H) In making any determination under this title with respect to the disability of a child who has not attained the age of 18 years and to whom section 221(h) does not apply, the Secretary shall make reasonable efforts to ensure that a qualified pediatrician or other individual who specializes in a field of medicine appropriate to the disability of the child (as determined by the Secretary) evaluates the case of such child.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to determinations made 6 or more months after the date of the enactment of this Act.

SEC. 5037. REIMBURSEMENT FOR VOCATIONAL REHABILITATION SERVICES FURNISHED DURING CERTAIN MONTHS OF NONPAYMENT OF SSI BENEFITS.

(a) **IN GENERAL.**—Section 1615 (42 U.S.C. 1382d) is amended by adding at the end the following:

“(e) The Secretary may reimburse the State agency described in subsection (d) for the costs described therein incurred in the provision of rehabilitation services—

“(1) for any month for which an individual received—

“(A) benefits under section 1611 or 1619(a);

“(B) assistance under section 1619(b); or

“(C) a federally administered State supplementary payment under section 1616 of this Act or section 212(b) of Public Law 93-66; and

“(2) for any month before the 13th consecutive month for which an individual, for a reason other than cessation of disability or blindness, was ineligible for—

“(A) benefits under section 1611 or 1619(a);

“(B) assistance under section 1619(b); or

“(C) a federally administered State supplementary payment under section 1616 of this Act or section 212(b) of Public Law 93-66.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to claims for reimbursement pending on or after such date.

SEC. 5038. EXTENSION OF PERIOD OF PRESUMPTIVE ELIGIBILITY FOR BENEFITS.

(a) **IN GENERAL.**—Section 1631(a)(4)(B) (42 U.S.C. 1383(a)(4)(B)) is amended by striking “3” and inserting “6”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to benefits for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5039. CONTINUING DISABILITY OR BLINDNESS REVIEWS NOT REQUIRED MORE THAN ONCE ANNUALLY.

(a) **IN GENERAL.**—Section 1619 (42 U.S.C. 1382h) is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

“(c) Subsection (a)(2) and section 1631(j)(2)(A) shall not be construed, singly or jointly, to require more than 1 determination during any 12-month period with respect to the continuing disability or blindness of an individual.”

(b) **CONFORMING AMENDMENT.**—Section 1631(j)(2)(A) (42 U.S.C. 1383(j)(2)(A)) is amended by inserting “(other than subsection (c) thereof)” after “1619” the 1st place such term appears.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 5040. CONCURRENT SSI AND FOOD STAMP APPLICATIONS BY INSTITUTIONALIZED INDIVIDUALS.

Section 1631 (42 U.S.C. 1383) is amended—

(1) in subsection (m), by striking the second sentence; and

(2) by adding at the end the following:

“Concurrent SSI and Food Stamp Applications by Institutionalized Individuals

“(n) The Secretary and the Secretary of Agriculture shall develop a procedure under which an individual who applies for supplemental security income benefits under this subsection shall also be permitted to apply at the same time for participation in the food stamp program authorized under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).”

SEC. 5041. NOTIFICATION OF CERTAIN INDIVIDUALS ELIGIBLE TO RECEIVE RETROACTIVE BENEFITS.

In notifying individuals of their eligibility to receive retroactive supplemental security income benefits as a result of *Sullivan v. Zebley*, 110 S. Ct. 2658 (1990), the Secretary shall include written notice, in language that is easily understandable, explaining—

(1) the 6-month limitation on the exclusion from resources under section 1613(a)(7) of the Social Security Act (42 U.S.C. 1382b(a)(7));

(2) the potential effects under title XVI of the Social Security Act, attributable to the receipt of such payment, including—

(A) potential discontinuation of eligibility; and

(B) potential reductions in the amount of benefits;

(3) the possibility of establishing a trust account that would not be considered as income or resources for the purposes of such title if the trust met certain conditions; and

(4) that legal assistance in establishing such a trust may be available through legal referral services offered by a State or local bar association, or through the Legal Services Corporation.

CHAPTER 4—AID TO FAMILIES WITH DEPENDENT CHILDREN

SEC. 5051. OPTIONAL MONTHLY REPORTING AND RETROSPECTIVE BUDGETING.

(a) **OPTIONAL MONTHLY REPORTING.**—Section 402(a)(14) (42 U.S.C. 602(a)(14)) is amended—

(1) by striking “with respect to” and all that follows through “(A) provide” and insert “provide, at the option of the State and with respect to such category or categories as the State may select and identify in its State plan (A)”;

(2) by striking “(with the prior approval of the Secretary in recent work history and earned income cases)”;

(3) by striking “upon a determination” and all that follows through “paragraph”.

(b) **OPTIONAL RETROSPECTIVE BUDGETING.**—Section 402(a)(13) (42 U.S.C. 602(a)(13)) is amended by striking all that precedes subparagraph (A) and inserting the following:

“(13) at the option of the State, but only with respect to any one or more categories of families required to report monthly to the State agency pursuant to paragraph (14), provide that—”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect with respect to reports pertaining to, or aid payable for, months beginning in or after October 1990.

SEC. 5052. CHILDREN RECEIVING FOSTER CARE MAINTENANCE OR ADOPTION ASSISTANCE PAYMENTS NOT TREATED AS MEMBER OF FAMILY UNIT FOR PURPOSES OF DETERMINING ELIGIBILITY FOR, OR AMOUNT OF, AFDC BENEFIT.

(a) **IN GENERAL.**—Part A of title IV (42 U.S.C. 601 et seq.) is amended by inserting after section 408 the following:

“EXCLUSION FROM AFDC UNIT OF CHILD FOR WHOM FEDERAL, STATE, OR LOCAL FOSTER CARE MAINTENANCE OR ADOPTION ASSISTANCE PAYMENTS ARE MADE

“SEC. 409. (a) Notwithstanding any other provision of this title (other than subsection (b))—

“(1) a child with respect to whom foster care maintenance payments or adoption assistance payments are made under part E or under State or local law shall not, for the period for which such payments are made, be regarded as a member of a family for purposes of determining the amount of benefits of the family under this part; and

“(2) the income and resources of such child shall be excluded from the income and resources of a family under this part.

“(b) Subsection (a) shall not apply in the case of a child with respect to whom adoption assistance payments are made under part E or under State or local law, if application of such subsection would reduce the benefits under this part of the family of which the child would otherwise be regarded as a member.”.

(b) **CONFORMING REPEAL.**—Section 478 (42 U.S.C. 678) is hereby repealed.

(c) **EFFECTIVE DATE.**—The amendment made by subsection (a) and the repeal made by subsection (b) shall apply with respect to benefits

for months beginning on or after the first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5053. ELIMINATION OF TERM "LEGAL GUARDIAN".

(a) **IN GENERAL.**—Section 402(a)(39) (42 U.S.C. 602(a)(39)) is amended—

(1) by striking "or legal guardian"; and

(2) by striking "or legal guardians".

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5054. REPORTING OF CHILD ABUSE AND NEGLECT.

(a) **CONCERNING AFDC APPLICANTS AND RECIPIENTS.**—

(1) **IN GENERAL.**—Section 402(a)(16) (42 U.S.C. 602(a)(16)) is amended to read as follows:

"(16) provide that the State agency will—

"(A) report to an appropriate agency or official, known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving aid under this part under circumstances which indicate that the child's health or welfare is threatened thereby; and

"(B) provide such information with respect to a situation described in subparagraph (A) as the State agency may have;"

(2) **CONFORMING AMENDMENTS.**—Section 402(a)(9) (42 U.S.C. 602(a)(9)) is amended—

(A) in subparagraph (C), by striking "and"; and

(B) by inserting ", and (E) reporting and providing information pursuant to paragraph (16) to appropriate authorities with respect to known or suspected child abuse or neglect" before the 1st semicolon.

(b) **CONCERNING RECIPIENTS OF FOSTER CARE OR ADOPTION ASSISTANCE.**—

(1) **IN GENERAL.**—Section 471(a)(9) (42 U.S.C. 671(a)(9)) is amended to read as follows:

"(9) provides that the State agency will—

"(A) report to an appropriate agency or official, known or suspected instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving aid under part B or this part under circumstances which indicate that the child's health or welfare is threatened thereby; and

"(B) provide such information with respect to a situation described in subparagraph (A) as the State agency may have;"

(2) **CONFORMING AMENDMENTS.**—Section 471(a)(8) (42 U.S.C. 671(a)(8)) is amended—

(A) in subparagraph (C), by striking "and"; and

(B) by inserting ", and (E) reporting and providing information pursuant to paragraph (9) to appropriate authorities with respect to known or suspected child abuse or neglect" before the 1st semicolon.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits for months beginning on or after the

first day of the 6th calendar month following the month in which this Act is enacted.

SEC. 5055. DISCLOSURE OF INFORMATION ABOUT AFDC APPLICANTS AND RECIPIENTS AUTHORIZED FOR PURPOSES DIRECTLY CONNECTED TO STATE FOSTER CARE AND ADOPTION ASSISTANCE PROGRAMS.

(a) **IN GENERAL.**—Section 402(a)(9)(A) (42 U.S.C. 602(a)(9)(A)) is amended by striking “or D” and inserting “, D, or E”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5056. REPATRIATION.

(a) **IN GENERAL.**—Section 1113 (42 U.S.C. 1313) is amended—

(1) in subsection (d), by striking “on or after October 1, 1989” and inserting “after September 30, 1991”; and

(2) by adding at the end the following:

“(e)(1) The Secretary may accept on behalf of the United States gifts, in cash or in kind, for use in carrying out the program established under this section. Gifts in the form of cash shall be credited to the appropriation account from which this program is funded, in addition to amounts otherwise appropriated, and shall remain available until expended.

“(2) Gifts accepted under paragraph (1) shall be available for obligation or other use by the United States only to the extent and in the amounts provided in appropriation Acts.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall be effective for fiscal years beginning after September 30, 1989.

SEC. 5057. TECHNICAL AMENDMENT TO NATIONAL COMMISSION ON CHILDREN.

Section 1139(d) (42 U.S.C. 1320b-9(d)) is amended in the matter preceding paragraph (1), by striking “an interim report no later than March 31, 1991, and a final report no later than September 30, 1990” and inserting “an interim report no later than September 30, 1990, and a final report no later than March 31, 1991”.

SEC. 5058. EXTENSION OF PROHIBITION AGAINST IMPLEMENTATION OF PROPOSED REGULATIONS ON EMERGENCY ASSISTANCE AND AFDC SPECIAL NEEDS.

Section 8005 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 606 note) is amended in each of subsections (a)(2) and (c) by striking “1990” and inserting “1991”.

SEC. 5059. AMENDMENTS TO MINNESOTA FAMILY INVESTMENT PLAN DEMONSTRATION.

Section 8015 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 602 note) is amended—

(1) in subsection (a), by striking “part A” and inserting “parts A and F”;

(2) in subsection (b)(3), by striking “(e)” and inserting “(d)”;

(3) in subsection (b)(6), by inserting “or that is assigned to and found eligible for the project” after “in the project”;

(4) in subsection (b)(8)(B)(ii), by inserting “(except that the age of the youngest child may be age 1 under the project even if the State plan specifies age 3)” after “such compliance”;

(5) in subsection (b)(8)(B)(ii)(I), by inserting “and” after the semicolon;

(6) in subsection (b)(8)(B)(ii), by striking “; and” after “age of 1 year” and all that follows through the end of subclause (III) and inserting “(except that, in a 2-parent family, this clause applies only to 1 parent).”;

(7) by amending subsection (b)(9) to read as follows:

“(9) **AVAILABILITY OF EDUCATION, EMPLOYMENT, AND TRAINING SERVICES.**—The State will make available education, employment, and training services equivalent to those services available under the State plan approved under part F of title IV of the Social Security Act to families required to enter into and comply with a contract with a county agency under the 1989 Minnesota Laws, section 10 of article 5 of chapter 282.”;

(8) in subsection (b)(10)(A)—

(A) by inserting “, except when a sanction is implemented under the 1989 Minnesota Laws, subdivision 3 of section 10 of article 5 of chapter 282,” after “ensure that”; and

(B) by striking “cash”;

(9) in subsection (b), by adding at the end the following:

“(12) **LIABILITY FOR COSTS.**—For each fiscal year, the Secretary shall not be liable for any costs related to carrying out the project in excess of those that the Secretary would have been liable for had the project not been implemented, except for costs for evaluating the project.”;

(10) in subsection (c)(1)(B), by striking “50” and inserting “25”;

(11) in subsection (c)(2), by striking “part A” and inserting “parts A and F”;

(12) in subsection (d)(1)(B)(ii)—

(A) by inserting “except when a sanction is implemented under the 1989 Minnesota Laws, subdivision 3 of section 10 of article 5 of chapter 282,” before “permit”; and

(B) by striking “cash”;

(13) in subsection (d)(1)(B)(iii), by striking “section 402(a)(19)(C) of such Act” and inserting “subparagraph (C), (D), or (E) of section 402(a)(19) of such Act (except that the exemption for a parent with a child under 1 year of age need not be specified in the State plan)”;

(14) by adding at the end the following:

“(i) **CONSTRUCTION.**—For purposes of any Federal, State, or local law other than part A of title IV of the Social Security Act, the Food Stamp Act of 1977, or this section—

“(1) families participating in the project shall be considered to be recipients of aid under such part; and

“(2) cash assistance provided under the project to any such family and not designated by the State as food assistance shall be treated as if such assistance were aid received under such part.”.

SEC. 5060. GOOD CAUSE EXCEPTION TO REQUIRED COOPERATION FOR TRANSITIONAL CHILD CARE BENEFITS.

(a) **IN GENERAL.**—Section 402(g)(1)(A)(vi)(II) (42 U.S.C. 602(g)(1)(A)(vi)(II)) is amended to read as follows:

“(II) refused to cooperate with the State in establishing and enforcing his or her child support obligations, without good cause as

determined by the State agency in accordance with standards prescribed by the Secretary which shall take into consideration the best interests of the child for whom child care is to be provided.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5061. TECHNICAL CORRECTIONS REGARDING PENALTY FOR FAILURE TO PARTICIPATE IN JOBS PROGRAM.

(a) **IN GENERAL.**—Section 407(b)(1)(B) (42 U.S.C. 607(b)(1)(B)) is amended—

(1) in clause (iii)—

(A) by striking “—” and all that follows through “(II)”;
and

(B) by striking “and ” at the end;

(2) in clause (iv), by striking the period and inserting “; and”;
and

(3) by adding at the end the following:

“(v) that, if and for so long as the child’s parent described in subparagraph (A)(i), unless meeting a condition of section 402(a)(19)(C), is, without good cause, not participating (or available for participation) in a program under part F, or if exempt under such section by reason of clause (vii) thereof or because there has not been established or provided under part F a program in which such parent can effectively participate, is not registered with the public employment offices in the State, the needs of such parent shall not be taken into account in determining the need of such parent’s family under section 402(a)(7), and the needs of such parent’s spouse shall not be so taken into account unless such spouse is participating in such a program, or if not participating solely by reason of section 402(a)(19)(C)(vii) or because there has not been established or provided under part F a program in which such spouse can effectively participate, is registered with the public employment offices of the State; and if neither parents’ needs are so taken into account, the payment provisions of section 402(a)(19)(G)(i)(I) shall apply.”

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect at the same time and in the same manner as the amendments made by title II of the Family Support Act of 1988 take effect.

SEC. 5062. TECHNICAL CORRECTIONS REGARDING AFDC-UP ELIGIBILITY REQUIREMENTS.

(a) **IN GENERAL.**—Section 407(d)(1) (42 U.S.C. 607(d)(1)) is amended—

(1) by striking “a calendar quarter (A)” and inserting “(A) a calendar quarter”;

(2) by striking “or” at the end of subparagraph (A); and

(3) by inserting “, and (C) a calendar quarter ending before October 1990 in which such individual participated in a community work experience program under section 409 (as in effect for a State immediately before the effective date for that State of the amendments made by title II of the Family Support Act of 1988) or the work incentive program established under part C

(as in effect for a State immediately before such effective date)" before the semicolon.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5063. FAMILY SUPPORT ACT DEMONSTRATION PROJECTS.

Section 505 of the Family Support Act of 1988 (42 U.S.C. 1315; P.L. 100-385) is amended—

(1) in subsection (a), by inserting "in each of the fiscal years 1990, 1991, and 1992," before "shall"; and

(2) in subsection (e), by striking "September 30, 1989" and inserting "September 30 of the fiscal year specified in the agreement described in subsection (a)".

SEC. 5064. STUDY OF JOBS PROGRAMS OPERATED BY INDIAN TRIBES AND ALASKA NATIVE ORGANIZATIONS.

(a) **IN GENERAL.**—Within 180 days after the date of the enactment of this Act, the Comptroller General of the United States (in this section referred to as the "Comptroller") shall conduct a study of the implementation of section 482(i) of the Social Security Act (42 U.S.C. 682(i)) relating to job opportunities and basic skills training programs (in this section referred to as "JOBS programs") operated by Indian tribes and Alaska Native organizations (as defined in paragraph (5) of such section 482(i)).

(b) **REQUIREMENTS FOR STUDY.**—In conducting the study described in subsection (a), the Comptroller shall—

(1) identify any problems associated with the implementation of section 482(i) of the Social Security Act; and

(2) assess (to the extent practicable) the effectiveness of the JOBS programs operated by Indian tribes and Alaska Native organizations.

(c) **REPORT.**—Upon completion of the study described in subsection (a), the Comptroller shall submit a report to the appropriate committees of the Congress that includes—

(1) a summary of the findings of the study; and

(2) recommendations with respect to proposed legislation or changes in administrative policy to improve the effectiveness of JOBS programs conducted pursuant to section 482(i) of the Social Security Act.

CHAPTER 5—CHILD WELFARE AND FOSTER CARE

SEC. 5071. ACCOUNTING FOR ADMINISTRATIVE COSTS.

(a) **RECLASSIFICATION.**—Section 474(a)(3) (42 U.S.C. 674(a)(3)) is amended by inserting "provision of child placement services and for the" before "proper and efficient".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 5072. SECTION 427 TRIENNIAL REVIEWS.

(a) **AMENDMENTS TO SECTION 10406 OF OBRA 1989.**—Section 10406 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 627 note) is amended—

(1) by striking "1991" and inserting "1992";

(2) by striking "1990" and inserting "1991"; and

(3) in the section heading, by striking "1990" and inserting "1991".

(b) **CONFORMING AMENDMENT.**—The item relating to section 10406 in the table of contents appearing immediately after section 10000 of such Act is amended by striking "1990" and inserting "1991".

SEC. 5073. INDEPENDENT LIVING INITIATIVES.

(a) **IN GENERAL.**—Section 477(a)(2)(C) (42 U.S.C. 677(a)(2)(C)) is amended—

(1) by inserting "who has not attained age 21" after "may at the option of the State also include any child"; and

(2) by striking ", but such child" and all that follows through "care".

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to payments made under part E of title IV of the Social Security Act for fiscal years beginning in or after fiscal year 1991.

CHAPTER 6—CHILD CARE

SEC. 5081. GRANTS TO STATES FOR CHILD CARE.

(a) **RULES GOVERNING PROVISION OF CHILD CARE TO ELIGIBLE FAMILIES.**—Section 402 (42 U.S.C. 602) is amended by adding at the end the following:

"(i)(1) Each State agency may, to the extent that it determines that resources are available, provide child care in accordance with paragraph (2) to any low income family that the State determines—

"(A) is not receiving aid under the State plan approved under this part;

"(B) needs such care in order to work; and

"(C) would be at risk of becoming eligible for aid under the State plan approved under this part if such care were not provided.

"(2) The State agency may provide child care pursuant to paragraph (1) by—

"(A) providing such care directly;

"(B) arranging such care through providers by use of purchase of service contracts or vouchers;

"(C) providing cash or vouchers in advance to the family;

"(D) reimbursing the family; or

"(E) adopting such other arrangements as the agency deems appropriate.

"(3)(A) A family provided with child care under paragraph (1) shall contribute to such care in accordance with a sliding scale formula established by the State agency based on the family's ability to pay.

"(B) The State agency shall make payment for the cost of child care provided under paragraph (1) with respect to a family in an amount that is the lesser of—

"(i) the actual cost of such care; and

"(ii) the applicable local market rate (as determined by the State in accordance with regulations issued by the Secretary).

"(4) The value of any child care provided or arranged (or any amount received as payment for such care or reimbursement for costs incurred for the care) under this subsection—

"(A) shall not be treated as income or as a deductible expense for purposes of any other Federal or federally assisted program that bases eligibility for or amount of benefits upon need; and

"(B) may not be claimed as an employment-related expense for purposes of the credit under section 21 of the Internal Revenue Code of 1986.

"(5) Amounts expended by the State agency for child care under paragraph (1) shall be treated as amounts for which payment may be made to a State under section 403(n) only to the extent that—

"(A) such amounts are paid in accordance with paragraph (3)(B);

"(B) the care involved meets applicable standards of State and local law;

"(C) the provider of the care—

"(i) in the case of a provider who is not an individual that provides such care solely to members of the family of the individual, is licensed, regulated, or registered by the State or locality in which the care is provided; and

"(ii) allows parental access; and

"(D) such amounts are not used to supplant any other Federal or State funds used for child care services.

"(6)(A)(i) Each State shall prepare reports annually, beginning with fiscal year 1993, on the activities of the State carried out with funds made available under section 403(n).

"(ii) The State shall make available for public inspection within the State copies of each report required by this paragraph, shall transmit a copy of each such report to the Secretary, and shall provide a copy of each such report, on request, to any interested public agency.

"(iii) The Secretary shall annually compile, and submit to the Congress, the State reports transmitted to the Secretary pursuant to clause (ii).

"(B) Each report prepared and transmitted by a State under subparagraph (A) shall set forth with respect to child care services provided under this subsection—

"(i) showing separately for center-based child care services, group home child care services, family child care services, and relative care services, the number of children who received such services and the average cost of such services;

"(ii) the criteria applied in determining eligibility or priority for receiving services, and sliding fee schedules;

"(iii) the child care licensing and regulatory (including registration) requirements in effect in the State with respect to each type of service specified in clause (i); and

"(iv) the enforcement policies and practices in effect in the State which apply to licensed and regulated child care providers (including providers required to register).

"(C) Within 12 months after the date of the enactment of this subsection, the Secretary shall establish uniform reporting requirements for use by the States in preparing the information required by this paragraph, and make such other provision as may be necessary or appropriate to ensure that compliance with this subsection will not be unduly burdensome on the States.

"(D) Not later than July 1, 1992, the Secretary shall issue a report on the implementation of this subsection, based on such information as has been made available to the Secretary by the States."

(b) PAYMENTS TO STATES.—Section 403 (42 U.S.C. 603) is amended by adding at the end the following:

"(n)(1) In addition to any payment under subsection (a) or (l), each State shall be entitled to payment from the Secretary of an amount equal to the lesser of—

"(A) the Federal medical assistance percentage (as defined in section 1905(b)) of the expenditures by the State in providing child care services pursuant to section 402(i), and in administering the provision of such child care services, for any fiscal year; and

"(B) the limitation determined under paragraph (2) with respect to the State for the fiscal year.

"(2)(A) The limitation determined under this paragraph with respect to a State for any fiscal year is the amount that bears the same ratio to the amount specified in subparagraph (B) for such fiscal year as the number of children residing in the State in the second preceding fiscal year bears to the number of children residing in the United States in the second preceding fiscal year.

"(B) The amount specified in this subparagraph is—

"(i) \$300,000,000 for fiscal year 1991;

"(ii) \$300,000,000 for fiscal year 1992;

"(iii) \$300,000,000 for fiscal year 1993;

"(iv) \$300,000,000 for fiscal year 1994; and

"(v) \$300,000,000 for fiscal year 1995, and for each fiscal year thereafter.

"(C) If the limitation determined under subparagraph (A) with respect to a State for a fiscal year exceeds the amount paid to the State under this subsection for the fiscal year, the limitation determined under this paragraph with respect to the State for the immediately succeeding fiscal year shall be increased by the amount of such excess.

"(3) Amounts appropriated for a fiscal year to carry out this part shall be made available for payments under this subsection for such fiscal year."

(c) AMENDMENTS TO GRANTS TO STATES TO IMPROVE CHILD CARE LICENSING AND REGISTRATION REQUIREMENTS, AND TO MONITOR CHILD CARE PROVIDED TO CHILDREN RECEIVING AFDC.—

(1) GRANTS INCREASED AND EXTENDED.—Section 402(g)(6)(D) (42 U.S.C. 602(g)(6)(D)) is amended by inserting "and \$50,000,000 for each of fiscal years 1992, 1993, and 1994" before the period.

(2) NEW PURPOSES FOR GRANTS.—Section 402(g)(6)(A) (42 U.S.C. 602(g)(6)(A)) is amended by striking "and to monitor child care provided to children receiving aid under the State plan approved under subsection (a)" and inserting "to enforce standards with respect to child care provided to children under this part, and to provide for the training of child care providers".

(3) HALF OF GRANT REQUIRED TO BE EXPENDED FOR TRAINING OF CHILD CARE PROVIDERS.—Section 402(g)(6) (42 U.S.C. 602(g)(6)) is amended by adding at the end the following:

"(E) Each State to which the Secretary makes a grant under this paragraph shall expend not less than 50 percent of the amount of the grant to provide for the training of child care providers."

(d) COORDINATION WITH OTHER PROGRAMS FOR CHILDREN.—Section 402(g)(7) (42 U.S.C. 602(g)(7)) is amended by inserting "and subsection (i)" after "this subsection".

(e) EFFECTIVE DATE.—Except as otherwise expressly provided, the amendments made by this section shall take effect on October 1, 1990.

SEC. 5082. CHILD CARE AND DEVELOPMENT BLOCK GRANT.

Chapter 8 of subtitle A of title IV of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) is amended—

(1) by redesignating subchapters C, D, and E, as subchapters D, E, and F, respectively; and

(2) by inserting after subchapter B the following new subchapter:

"Subchapter C—Child Care and Development Block Grant

"SEC. 658A. SHORT TITLE.

"This subchapter may be cited as the 'Child Care and Development Block Grant Act of 1990'.

"SEC. 658B. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated to carry out this subchapter, \$750,000,000 for fiscal year 1991, \$825,000,000 for fiscal year 1992, \$925,000,000 for fiscal year 1993, and such sums as may be necessary for each of the fiscal years 1994 and 1995.

"SEC. 658C. ESTABLISHMENT OF BLOCK GRANT PROGRAM.

"The Secretary is authorized to make grants to States in accordance with the provisions of this subchapter.

"SEC. 658D. LEAD AGENCY.

"(a) DESIGNATION.—The chief executive officer of a State desiring to receive a grant under this subchapter shall designate, in an application submitted to the Secretary under section 658E, an appropriate State agency that complies with the requirements of subsection (b) to act as the lead agency.

"(b) DUTIES.—

"(1) IN GENERAL.—The lead agency shall—

"(A) administer, directly or through other State agencies, the financial assistance received under this subchapter by the State;

"(B) develop the State plan to be submitted to the Secretary under section 658E(a);

"(C) in conjunction with the development of the State plan as required under subparagraph (B), hold at least one hearing in the State to provide to the public an opportunity to comment on the provision of child care services under the State plan; and

"(D) coordinate the provision of services under this subchapter with other Federal, State and local child care and early childhood development programs.

"(2) DEVELOPMENT OF PLAN.—In the development of the State plan described in paragraph (1)(B), the lead agency shall consult with appropriate representatives of units of general purpose local government. Such consultations may include consideration of local child care needs and resources, the effectiveness of existing child care and early childhood development services, and the methods by which funds made available under this subchapter can be used to effectively address local shortages.

"SEC. 658E. APPLICATION AND PLAN.

"(a) APPLICATION.—To be eligible to receive assistance under this subchapter, a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary shall by rule require, including—

"(1) an assurance that the State will comply with the requirements of this subchapter; and

"(2) a State plan that meets the requirements of subsection (c).

"(b) PERIOD COVERED BY PLAN.—The State plan contained in the application under subsection (a) shall be designed to be implemented—

"(1) during a 3-year period for the initial State plan; and

"(2) during a 2-year period for subsequent State plans.

"(c) REQUIREMENTS OF A PLAN.—

"(1) LEAD AGENCY.—The State plan shall identify the lead agency designated under section 658D.

"(2) POLICIES AND PROCEDURES.—The State plan shall:

"(A) PARENTAL CHOICE OF PROVIDERS.—Provide assurances that—

"(i) the parent or parents of each eligible child within the State who receives or is offered child care services for which financial assistance is provided under this subchapter, other than through assistance provided under paragraph (3)(C), are given the option either—

"(I) to enroll such child with a child care provider that has a grant or contract for the provision of such services; or

"(II) to receive a child care certificate as defined in section 658P(2);

"(ii) in cases in which the parent selects the option described in clause (i)(I), the child will be enrolled with the eligible provider selected by the parent to the maximum extent practicable; and

"(iii) child care certificates offered to parents selecting the option described in clause (i)(II) shall be of a value commensurate with the subsidy value of child care services provided under the option described in clause (i)(I);

except that nothing in this subparagraph shall require a State to have a child care certificate program in operation prior to October 1, 1992.

"(B) UNLIMITED PARENTAL ACCESS.—Provide assurances that procedures are in effect within the State to ensure that child care providers who provide services for which assist-

ance is made available under this subchapter afford parents unlimited access to their children and to the providers caring for their children, during the normal hours of operation of such providers and whenever such children are in the care of such providers.

"(C) PARENTAL COMPLAINTS.—Provide assurances that the State maintains a record of substantiated parental complaints and makes information regarding such parental complaints available to the public on request.

"(D) CONSUMER EDUCATION.—Provide assurances that consumer education information will be made available to parents and the general public within the State concerning licensing and regulatory requirements, complaint procedures, and policies and practices relative to child care services within the State.

"(E) COMPLIANCE WITH STATE AND LOCAL REGULATORY REQUIREMENTS.—Provide assurances that—

"(i) all providers of child care services within the State for which assistance is provided under this subchapter comply with all licensing or regulatory requirements (including registration requirements) applicable under State and local law; and

"(ii) providers within the State that are not required to be licensed or regulated under State or local law are required to be registered with the State prior to payment being made under this subchapter, in accordance with procedures designed to facilitate appropriate payment to such providers, and to permit the State to furnish information to such providers, including information on the availability of health and safety training, technical assistance, and any relevant information pertaining to regulatory requirements in the State, and that such providers shall be permitted to register with the State after selection by the parents of eligible children and before such payment is made.

This subparagraph shall not be construed to prohibit a State from imposing more stringent standards and licensing or regulatory requirements on child care providers within the State that provide services for which assistance is provided under this subchapter than the standards or requirements imposed on other child care providers in the State.

"(F) ESTABLISHMENT OF HEALTH AND SAFETY REQUIREMENTS.—Provide assurances that there are in effect within the State, under State or local law, requirements designed to protect the health and safety of children that are applicable to child care providers that provide services for which assistance is made available under this subchapter. Such requirements shall include—

"(i) the prevention and control of infectious diseases (including immunization);

"(ii) building and physical premises safety; and

"(iii) minimum health and safety training appropriate to the provider setting.

Nothing in this subparagraph shall be construed to require the establishment of additional health and safety requirements for child care providers that are subject to health and safety requirements in the categories described in this subparagraph on the date of enactment of this subchapter under State or local law.

"(G) COMPLIANCE WITH STATE AND LOCAL HEALTH AND SAFETY REQUIREMENTS.—Provide assurances that procedures are in effect to ensure that child care providers within the State that provide services for which assistance is provided under this subchapter comply with all applicable State or local health and safety requirements as described in subparagraph (F).

"(H) REDUCTION IN STANDARDS.—Provide assurances that if the State reduces the level of standards applicable to child care services provided in the State on the date of enactment of this subchapter, the State shall inform the Secretary of the rationale for such reduction in the annual report of the State described in section 658K.

"(I) REVIEW OF STATE LICENSING AND REGULATORY REQUIREMENTS.—Provide assurances that not later than 18 months after the date of the submission of the application under section 658E, the State will complete a full review of the law applicable to, and the licensing and regulatory requirements and policies of, each licensing agency that regulates child care services and programs in the State unless the State has reviewed such law, requirements, and policies in the 3-year period ending on the date of the enactment of this subchapter.

"(J) SUPPLEMENTATION.—Provide assurances that funds received under this subchapter by the State will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended for the support of child care services and related programs in the State.

"(3) USE OF BLOCK GRANT FUNDS.—

"(A) GENERAL REQUIREMENT.—The State plan shall provide that the State will use the amounts provided to the State for each fiscal year under this subchapter as required under subparagraphs (B) and (C).

"(B) CHILD CARE SERVICES.—Subject to the reservation contained in subparagraph (C), the State shall use amounts provided to the State for each fiscal year under this subchapter for—

"(i) child care services, that meet the requirements of this subchapter, that are provided to eligible children in the State on a sliding fee scale basis using funding methods provided for in section 658E(c)(2)(A), with priority being given for services provided to children of families with very low family incomes (taking into consideration family size) and to children with special needs; and

"(ii) activities designed to improve the availability and quality of child care.

“(C) **ACTIVITIES TO IMPROVE THE QUALITY OF CHILD CARE AND TO INCREASE THE AVAILABILITY OF EARLY CHILDHOOD DEVELOPMENT AND BEFORE- AND AFTER-SCHOOL CARE SERVICES.**—The State shall reserve 25 percent of the amounts provided to the State for each fiscal year under this subchapter to carry out activities designed to improve the quality of child care (as described in section 658G) and to provide before- and after-school and early childhood development services (as described in section 658H).

“(4) **PAYMENT RATES.**—

“(A) **IN GENERAL.**—The State plan shall provide assurances that payment rates for the provision of child care services for which assistance is provided under this subchapter are sufficient to ensure equal access for eligible children to comparable child care services in the State or substate area that are provided to children whose parents are not eligible to receive assistance under this subchapter or for child care assistance under any other Federal or State programs. Such payment rates shall take into account the variations in the costs of providing child care in different settings and to children of different age groups, and the additional costs of providing child care for children with special needs.

“(B) **CONSTRUCTION.**—Nothing in this paragraph shall be construed to create a private right of action.

“(5) **SLIDING FEE SCALE.**—The State plan shall provide that the State will establish and periodically revise, by rule, a sliding fee scale that provides for cost sharing by the families that receive child care services for which assistance is provided under this subchapter.

“(d) **APPROVAL OF APPLICATION.**—The Secretary shall approve an application that satisfies the requirements of this section.

“**SEC. 658F. LIMITATIONS ON STATE ALLOTMENTS.**

“(a) **NO ENTITLEMENT TO CONTRACT OR GRANT.**—Nothing in this subchapter shall be construed—

“(1) to entitle any child care provider or recipient of a child care certificate to any contract, grant or benefit; or

“(2) to limit the right of any State to impose additional limitations or conditions on contracts or grants funded under this subchapter.

“(b) **CONSTRUCTION OF FACILITIES.**—

“(1) **IN GENERAL.**—No funds made available under this subchapter shall be expended for the purchase or improvement of land, or for the purchase, construction, or permanent improvement (other than minor remodeling) of any building or facility.

“(2) **SECTARIAN AGENCY OR ORGANIZATION.**—In the case of a sectarian agency or organization, no funds made available under this subchapter may be used for the purposes described in paragraph (1) except to the extent that renovation or repair is necessary to bring the facility of such agency or organization into compliance with health and safety requirements referred to in section 658E(c)(2)(F).

"SEC. 658G. ACTIVITIES TO IMPROVE THE QUALITY OF CHILD CARE.

"A State that receives financial assistance under this subchapter shall use not less than 20 percent of the amounts reserved by such State under section 658E(c)(3)(C) for each fiscal year for one or more of the following:

"(1) **RESOURCE AND REFERRAL PROGRAMS.**—Operating directly or providing financial assistance to private nonprofit organizations or public organizations (including units of general purpose local government) for the development, establishment, expansion, operation, and coordination of resource and referral programs specifically related to child care.

"(2) **GRANTS OR LOANS TO ASSIST IN MEETING STATE AND LOCAL STANDARDS.**—Making grants or providing loans to child care providers to assist such providers in meeting applicable State and local child care standards.

"(3) **MONITORING OF COMPLIANCE WITH LICENSING AND REGULATORY REQUIREMENTS.**—Improving the monitoring of compliance with, and enforcement of, State and local licensing and regulatory requirements (including registration requirements).

"(4) **TRAINING.**—Providing training and technical assistance in areas appropriate to the provision of child care services, such as training in health and safety, nutrition, first aid, the recognition of communicable diseases, child abuse detection and prevention, and the care of children with special needs.

"(5) **COMPENSATION.**—Improving salaries and other compensation paid to full- and part-time staff who provide child care services for which assistance is provided under this subchapter.

"SEC. 658H. EARLY CHILDHOOD DEVELOPMENT AND BEFORE- AND AFTER-SCHOOL SERVICES.

"(a) **IN GENERAL.**—A State that receives financial assistance under this subchapter shall use not less than 75 percent of the amounts reserved by such State under section 658E(c)(3)(C) for each fiscal year to establish or expand and conduct, through the provision of grants or contracts, early childhood development or before- and after-school child care programs, or both.

"(b) **PROGRAM DESCRIPTION.**—Programs that receive assistance under this section shall—

"(1) in the case of early childhood development programs, consist of services that are not intended to serve as a substitute for a compulsory academic programs but that are intended to provide an environment that enhances the educational, social, cultural, emotional, and recreational development of children; and

"(2) in the case of before- and after-school child care programs—

"(A) be provided Monday through Friday, including school holidays and vacation periods other than legal public holidays, to children attending early childhood development programs, kindergarten, or elementary or secondary school classes during such times of the day and on such days that regular instructional services are not in session; and

"(B) not be intended to extend or replace the regular academic program.

"(c) **PRIORITY FOR ASSISTANCE.**—In awarding grants and contracts under this section, the State shall give the highest priority to geographic areas within the State that are eligible to receive grants under section 1006 of the Elementary and Secondary Education Act of 1965, and shall then give priority to—

"(1) any other areas with concentrations of poverty; and

"(2) any areas with very high or very low population densities.

"SEC. 658I. ADMINISTRATION AND ENFORCEMENT.

"(a) **ADMINISTRATION.**—The Secretary shall—

"(1) coordinate all activities of the Department of Health and Human Services relating to child care, and, to the maximum extent practicable, coordinate such activities with similar activities of other Federal entities;

"(2) collect, publish and make available to the public a listing of State child care standards at least once every 3 years; and

"(3) provide technical assistance to assist States to carry out this subchapter, including assistance on a reimbursable basis.

"(b) **ENFORCEMENT.**—

"(1) **REVIEW OF COMPLIANCE WITH STATE PLAN.**—The Secretary shall review and monitor State compliance with this subchapter and the plan approved under section 658E(c) for the State, and shall have the power to terminate payments to the State in accordance with paragraph (2).

"(2) **NONCOMPLIANCE.**—

"(A) **IN GENERAL.**—If the Secretary, after reasonable notice to a State and opportunity for a hearing, finds that—

"(i) there has been a failure by the State to comply substantially with any provision or requirement set forth in the plan approved under section 658E(c) for the State; or

"(ii) in the operation of any program for which assistance is provided under this subchapter there is a failure by the State to comply substantially with any provision of this subchapter;

the Secretary shall notify the State of the finding and that no further payments may be made to such State under this subchapter (or, in the case of noncompliance in the operation of a program or activity, that no further payments to the State will be made with respect to such program or activity) until the Secretary is satisfied that there is no longer any such failure to comply or that the noncompliance will be promptly corrected.

"(B) **ADDITIONAL SANCTIONS.**—In the case of a finding of noncompliance made pursuant to subparagraph (A), the Secretary may, in addition to imposing the sanctions described in such subparagraph, impose other appropriate sanctions, including recoupment of money improperly expended for purposes prohibited or not authorized by this

subchapter, and disqualification from the receipt of financial assistance under this subchapter.

“(C) NOTICE.—The notice required under subparagraph (A) shall include a specific identification of any additional sanction being imposed under subparagraph (B).

“(3) ISSUANCE OF RULES.—The Secretary shall establish by rule procedures for—

“(A) receiving, processing, and determining the validity of complaints concerning any failure of a State to comply with the State plan or any requirement of this subchapter; and

“(B) imposing sanctions under this section.

“SEC. 658J. PAYMENTS.

“(a) IN GENERAL.—Subject to the availability of appropriations, a State that has an application approved by the Secretary under section 658E(d) shall be entitled to a payment under this section for each fiscal year in an amount equal to its allotment under section 658O for such fiscal year.

“(b) METHOD OF PAYMENT.—

“(1) IN GENERAL.—Subject to paragraph (2), the Secretary may make payments to a State in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Secretary may determine.

“(2) LIMITATION.—The Secretary may not make such payments in a manner that prevents the State from complying with the requirement specified in section 658E(c)(3).

“(c) SPENDING OF FUNDS BY STATE.—Payments to a State from the allotment under section 658O for any fiscal year may be expended by the State in that fiscal year or in the succeeding fiscal year.

“SEC. 658K. ANNUAL REPORT AND AUDITS.

“(a) ANNUAL REPORT.—Not later than December 31, 1992, and annually thereafter, a State that receives assistance under this subchapter shall prepare and submit to the Secretary a report—

“(1) specifying the uses for which the State expended funds specified under paragraph (3) of section 658E(c) and the amount of funds expended for such uses;

“(2) containing available data on the manner in which the child care needs of families in the State are being fulfilled, including information concerning—

“(A) the number of children being assisted with funds provided under this subchapter, and under other Federal child care and pre-school programs;

“(B) the type and number of child care programs, child care providers, caregivers, and support personnel located in the State;

“(C) salaries and other compensation paid to full- and part-time staff who provide child care services; and

“(D) activities in the State to encourage public-private partnerships that promote business involvement in meeting child care needs;

“(3) describing the extent to which the affordability and availability of child care services has increased;

"(4) if applicable, describing, in either the first or second such report, the findings of the review of State licensing and regulatory requirements and policies described in section 658E(c), including a description of actions taken by the State in response to such reviews;

"(5) containing an explanation of any State action, in accordance with section 658E, to reduce the level of child care standards in the State, if applicable; and

"(6) describing the standards and health and safety requirements applicable to child care providers in the State, including a description of State efforts to improve the quality of child care;

during the period for which such report is required to be submitted.

"(b) AUDITS.—

"(1) REQUIREMENT.—A State shall, after the close of each program period covered by an application approved under section 658E(d) audit its expenditures during such program period from amounts received under this subchapter.

"(2) INDEPENDENT AUDITOR.—Audits under this subsection shall be conducted by an entity that is independent of any agency administering activities that receive assistance under this subchapter and be in accordance with generally accepted auditing principles.

"(3) SUBMISSION.—Not later than 30 days after the completion of an audit under this subsection, the State shall submit a copy of the audit to the legislature of the State and to the Secretary.

"(4) REPAYMENT OF AMOUNTS.—Each State shall repay to the United States any amounts determined through an audit under this subsection not to have been expended in accordance with this subchapter, or the Secretary may offset such amounts against any other amount to which the State is or may be entitled under this subchapter.

"SEC. 658L. REPORT BY SECRETARY.

"Not later than July 31, 1993, and annually thereafter, the Secretary shall prepare and submit to the Committee on Education and Labor of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report that contains a summary and analysis of the data and information provided to the Secretary in the State reports submitted under section 658K. Such report shall include an assessment, and where appropriate, recommendations for the Congress concerning efforts that should be undertaken to improve the access of the public to quality and affordable child care in the United States.

"SEC. 658M. LIMITATIONS ON USE OF FINANCIAL ASSISTANCE FOR CERTAIN PURPOSES.

"(a) SECTARIAN PURPOSES AND ACTIVITIES.—No financial assistance provided under this subchapter, pursuant to the choice of a parent under section 658E(c)(2)(A)(i)(I) or through any other grant or contract under the State plan, shall be expended for any sectarian purpose or activity, including sectarian worship or instruction.

"(b) TUITION.—With regard to services provided to students enrolled in grades 1 through 12, no financial assistance provided under this subchapter shall be expended for—

"(1) any services provided to such students during the regular school day;

"(2) any services for which such students receive academic credit toward graduation; or

"(3) any instructional services which supplant or duplicate the academic program of any public or private school.

"SEC. 658N. NONDISCRIMINATION.

"(a) RELIGIOUS NONDISCRIMINATION.—

"(1) **CONSTRUCTION.**—nothing in this section shall be construed to modify or affect the provisions of any other Federal law or regulation that relates to discrimination in employment on the basis of religion.

"(B) **EXCEPTION.**—A sectarian organization may require that employees adhere to the religious tenets and teachings of such organization, and such organization may require that employees adhere to rules forbidding the use of drugs or alcohol.

"(2) DISCRIMINATION AGAINST CHILD.—

"(A) **IN GENERAL.**—A child care provider (other than a family child care provider) that receives assistance under this subchapter shall not discriminate against any child on the basis of religion in providing child care services.

"(B) **NON-FUNDED CHILD CARE SLOTS.**—Nothing in this section shall prohibit a child care provider from selecting children for child care slots that are not funded directly with assistance provided under this subchapter because such children or their family members participate on a regular basis in other activities of the organization that owns or operates such provider.

"(3) EMPLOYMENT IN GENERAL.—

"(A) **PROHIBITION.**—A child care provider that receives assistance under this subchapter shall not discriminate in employment on the basis of the religion of the prospective employee if such employee's primary responsibility is or will be working directly with children in the provision of child care services.

"(B) **QUALIFIED APPLICANTS.**—If two or more prospective employees are qualified for any position with a child care provider receiving assistance under this subchapter, nothing in this section shall prohibit such child care provider from employing a prospective employee who is already participating on a regular basis in other activities of the organization that owns or operates such provider.

"(C) **PRESENT EMPLOYEES.**—This paragraph shall not apply to employees of child care providers receiving assistance under this subchapter if such employees are employed with the provider on the date of enactment of this subchapter.

"(4) **EMPLOYMENT AND ADMISSION PRACTICES.**—Notwithstanding paragraphs (1)(B), (2), and (3), if assistance provided under this subchapter, and any other Federal or State program, amounts to 80 percent or more of the operating budget of a child care provider that receives such assistance, the Secretary

shall not permit such provider to receive any further assistance under this subchapter unless the grant or contract relating to the financial assistance, or the employment and admissions policies of the provider, specifically provides that no person with responsibilities in the operation of the child care program, project, or activity of the provider will discriminate against any individual in employment, if such employee's primary responsibility is or will be working directly with children in the provision of child care, or admissions because of the religion of such individual.

“(b) **EFFECT ON STATE LAW.**—Nothing in this subchapter shall be construed to supersede or modify any provision of a State constitution or State law that prohibits the expenditure of public funds in or by sectarian institutions, except that no provision of a State constitution or State law shall be construed to prohibit the expenditure in or by sectarian institutions of any Federal funds provided under this subchapter.

“**SEC. 6580. AMOUNTS RESERVED; ALLOTMENTS.**

“(a) **AMOUNTS RESERVED.**—

“(1) **TERRITORIES AND POSSESSIONS.**—The Secretary shall reserve not to exceed one half of 1 percent of the amount appropriated under this subchapter in each fiscal year for payments to Guam, American Samoa, the Virgin Islands of the United States, the Commonwealth of the Northern Mariana Islands, and the Trust Territory of the Pacific Islands to be allotted in accordance with their respective needs.

“(2) **INDIANS TRIBES.**—The Secretary shall reserve not more than 3 percent of the amount appropriated under section 658B in each fiscal year for payments to Indian tribes and tribal organizations with applications approved under subsection (c).

“(b) **STATE ALLOTMENT.**—

“(1) **GENERAL RULE.**—From the amounts appropriated under section 658B for each fiscal year remaining after reservations under subsection (a), the Secretary shall allot to each State an amount equal to the sum of—

“(A) an amount that bears the same ratio to 50 percent of such remainder as the product of the young child factor of the State and the allotment percentage of the State bears to the sum of the corresponding products for all States; and

“(B) an amount that bears the same ratio to 50 percent of such remainder as the product of the school lunch factor of the State and the allotment percentage of the State bears to the sum of the corresponding products for all States.

“(2) **YOUNG CHILD FACTOR.**—The term ‘young child factor’ means the ratio of the number of children in the State under 5 years of age to the number of such children in all States as provided by the most recent annual estimates of population in the States by the Census Bureau of the Department of Commerce.

“(3) **SCHOOL LUNCH FACTOR.**—The term ‘school lunch factor’ means the ratio of the number of children in the State who are receiving free or reduced price lunches under the school lunch program established under the National School Lunch Act (42 U.S.C. 1751 et seq.) to the number of such children in all the

States as determined annually by the Department of Agriculture.

"(4) ALLOTMENT PERCENTAGE.—

"(A) IN GENERAL.—The allotment percentage for a State is determined by dividing the per capita income of all individuals in the United States, by the per capita income of all individuals in the State.

"(B) LIMITATIONS.—If an allotment percentage determined under subparagraph (A)—

"(i) exceeds 1.2 percent, then the allotment percentage of that State shall be considered to be 1.2 percent; and

"(ii) is less than 0.8 percent, then the allotment percentage of the State shall be considered to be 0.8 percent.

"(C) PER CAPITA INCOME.—For purposes of subparagraph (A), per capita income shall be—

"(i) determined at 2-year intervals;

"(ii) applied for the 2-year period beginning on October 1 of the first fiscal year beginning on the date such determination is made; and

"(iii) equal to the average of the annual per capita incomes for the most recent period of 3 consecutive years for which satisfactory data are available from the Department of Commerce at the time such determination is made.

"(c) PAYMENTS FOR THE BENEFIT OF INDIAN CHILDREN.—

"(1) GENERAL AUTHORITY.—From amounts reserved under subsection (a)(2), the Secretary may make grants to or enter into contracts with Indian tribes or tribal organizations that submit applications under this section, for the planning and carrying out of programs or activities consistent with the purposes of this subchapter.

"(2) APPLICATIONS AND REQUIREMENTS.—An application for a grant or contract under this section shall provide that:

"(A) COORDINATION.—The applicant will coordinate, to the maximum extent feasible, with the lead agency in the State or States in which the applicant will carry out programs or activities under this section.

"(B) SERVICES ON RESERVATIONS.—In the case of an applicant located in a State other than Alaska, California, or Oklahoma, programs and activities under this section will be carried out on the Indian reservation for the benefit of Indian children.

"(C) REPORTS AND AUDITS.—The applicant will make such reports on, and conduct such audits of, programs and activities under a grant or contract under this section as the Secretary may require.

"(3) CONSIDERATION OF SECRETARIAL APPROVAL.—In determining whether to approve an application for a grant or contract under this section, the Secretary shall take into consideration—

"(A) the availability of child care services provided in accordance with this subchapter by the State or States in

which the applicant proposes to carry out a program to provide child care services; and

“(B) whether the applicant has the ability (including skills, personnel, resources, community support, and other necessary components) to satisfactorily carry out the proposed program or activity.

“(4) **THREE-YEAR LIMIT.**—Grants or contracts under this section shall be for periods not to exceed 3 years.

“(5) **DUAL ELIGIBILITY OF INDIAN CHILDREN.**—The awarding of a grant or contract under this section for programs or activities to be conducted in a State or States shall not affect the eligibility of any Indian child to receive services provided or to participate in programs and activities carried out under a grant to the State or States under this subchapter.

“(d) **DATA AND INFORMATION.**—The Secretary shall obtain from each appropriate Federal agency, the most recent data and information necessary to determine the allotments provided for in subsection (b).

“(e) **REALLOTMENTS.**—

“(1) **IN GENERAL.**—Any portion of the allotment under subsection (b) to a State that the Secretary determines is not required to carry out a State plan approved under section 658E(d), in the period for which the allotment is made available, shall be reallocated by the Secretary to other States in proportion to the original allotments to the other States.

“(2) **LIMITATIONS.**—

“(A) **REDUCTION.**—The amount of any reallocation to which a State is entitled to under paragraph (1) shall be reduced to the extent that it exceeds the amount that the Secretary estimates will be used in the State to carry out a State plan approved under section 658E(d).

“(B) **REALLOTMENTS.**—The amount of such reduction shall be similarly reallocated among States for which no reduction in an allotment or reallocation is required by this subsection.

“(3) **AMOUNTS REALLOCATED.**—For purposes of any other section of this subchapter, any amount reallocated to a State under this subsection shall be considered to be part of the allotment made under subsection (b) to the State.

“(f) **DEFINITION.**—For the purposes of this section, the term ‘State’ includes only the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

“**SEC. 658P. DEFINITIONS.**

“As used in this subchapter:

“(1) **CAREGIVER.**—The term ‘caregiver’ means an individual who provides a service directly to an eligible child on a person-to-person basis.

“(2) **CHILD CARE CERTIFICATE.**—The term ‘child care certificate’ means a certificate (that may be a check or other disbursement) that is issued by a State or local government under this subchapter directly to a parent who may use such certificate only as payment for child care services. Nothing in this subchapter shall preclude the use of such certificates for sectarian

child care services if freely chosen by the parent. For purposes of this subchapter, child care certificates shall not be considered to be grants or contracts.

"(3) **ELEMENTARY SCHOOL.**—The term 'elementary school' means a day or residential school that provides elementary education, as determined under State law.

"(4) **ELIGIBLE CHILD.**—The term 'eligible child' means an individual—

"(A) who is less than 13 years of age;

"(B) whose family income does not exceed 75 percent of the State median income for a family of the same size; and

"(C) who—

"(i) resides with a parent or parents who are working or attending a job training or educational program; or

"(ii) is receiving, or needs to receive, protective services and resides with a parent or parents not described in clause (i).

"(5) **ELIGIBLE CHILD CARE PROVIDER.**—The term 'eligible child care provider' means—

"(A) a center-based child care provider, a group home child care provider, a family child care provider, or other provider of child care services for compensation that—

"(i) is licensed, regulated, or registered under State law as described in section 658E(c)(2)(E); and

"(ii) satisfies the State and local requirements, including those referred to in section 658E(c)(2)(F); applicable to the child care services it provides; or

"(B) a child care provider that is 18 years of age or older who provides child care services only to eligible children who are, by affinity or consanguinity, or by court decree, the grandchild, niece, or nephew of such provider, if such provider is registered and complies with any State requirements that govern child care provided by the relative involved.

"(6) **FAMILY CHILD CARE PROVIDER.**—The term 'family child care provider' means one individual who provides child care services for fewer than 24 hours per day, as the sole caregiver, and in a private residence.

"(7) **INDIAN TRIBE.**—The term 'Indian tribe' has the meaning given it in section 4(b) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(b)).

"(8) **LEAD AGENCY.**—The term 'lead agency' means the agency designated under section 658B(a).

"(9) **PARENT.**—The term 'parent' includes a legal guardian or other person standing in loco parentis.

"(10) **SECONDARY SCHOOL.**—The term 'secondary school' means a day or residential school which provides secondary education, as determined under State law.

"(11) **SECRETARY.**—The term 'Secretary' means the Secretary of Health and Human Services unless the context specifies otherwise.

"(12) **SLIDING FEE SCALE.**—The term 'sliding fee scale' means a system of cost sharing by a family based on income and size of the family.

"(13) STATE.—The term 'State' means any of the several States, the District of Columbia, the Virgin Islands of the United States, the Commonwealth of Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the Trust Territory of the Pacific Islands.

"(14) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given it in section 4(c) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(c)).

"SEC. 658Q. PARENTAL RIGHTS AND RESPONSIBILITIES.

"Nothing in this subchapter shall be construed or applied in any manner to infringe on or usurp the moral and legal rights and responsibilities of parents or legal guardians.

"SEC. 658R. SEVERABILITY.

"If any provision of this subchapter or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions of applications of this subchapter which can be given effect without regard to the invalid provision or application, and to this end the provisions of this subchapter shall be severable."

Subtitle B—Old-Age, Survivors, and Disability Insurance

SEC. 5100. TABLE OF CONTENTS.

Sec. 5100. Table of contents.

Sec. 5101. Amendment of the Social Security Act.

Sec. 5102. Continuation of disability benefits during appeal.

Sec. 5103. Repeal of special disability standard for widows and widowers.

Sec. 5104. Dependency requirements applicable to a child adopted by a surviving spouse.

Sec. 5105. Representative payee reforms.

Sec. 5106. Fees for representation of claimants in administrative proceedings.

Sec. 5107. Applicability of administrative res judicata; related notice requirements.

Sec. 5108. Demonstration projects relating to accountability for telephone service center communications.

Sec. 5109. Notice requirements.

Sec. 5110. Telephone access to the Social Security Administration.

Sec. 5111. Amendments relating to social security account statements.

Sec. 5112. Trial work period during rolling five-year period for all disabled beneficiaries.

Sec. 5113. Continuation of benefits on account of participation in a non-state vocational rehabilitation program.

Sec. 5114. Limitation on new entitlement to special age-72 payments.

Sec. 5115. Elimination of advanced crediting to the trust funds of social security payroll taxes.

Sec. 5116. Elimination of eligibility for retroactive benefits for certain individuals eligible for reduced benefits

Sec. 5117. Consolidation of old methods of computing primary insurance amounts.

Sec. 5118. Suspension of dependent's benefits when the worker is in an extended period of eligibility.

Sec. 5119. Entitlement to benefits of deemed spouse and legal spouse.

Sec. 5120. Vocational rehabilitation demonstration projects.

Sec. 5121. Exemption for certain aliens, receiving amnesty under the Immigration and Nationality Act, from prosecution for misreporting of earnings or misuse of social security account numbers or social security cards.

Sec. 5122. Reduction of amount of wages needed to earn a year of coverage applicable in determining special minimum primary insurance amount.

Sec. 5123. Charging of earnings of corporate directors.

Sec. 5124. Collection of employee social security and railroad retirement taxes on taxable group-term life insurance provided to retirees.

- Sec. 5125. Tier 1 railroad retirement tax rates explicitly determined by reference to social security taxes.
- Sec. 5126. Transfer to railroad retirement account.
- Sec. 5127. Waiver of 2-year waiting period for independent entitlement to divorced spouse's benefits.
- Sec. 5128. Modification of the preeffectuation review requirement applicable to disability insurance cases.
- Sec. 5129. Recovery of OASDI overpayments by means of reduction in tax refunds.
- Sec. 5130. Miscellaneous technical corrections.

SEC. 5101. AMENDMENT OF THE SOCIAL SECURITY ACT.

Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

SEC. 5102. CONTINUATION OF DISABILITY BENEFITS DURING APPEAL.

Subsection (g) of section 223 (42 U.S.C. 423(g)) is amended—

- (1) in paragraph (1), in the matter following subparagraph (C), by inserting "or" after "hearing," and by striking "pending, or (iii) June 1991." and inserting "pending."; and
- (2) by striking paragraph (3).

SEC. 5103. REPEAL OF SPECIAL DISABILITY STANDARD FOR WIDOWS AND WIDOWERS.

(a) **IN GENERAL.**—Section 223(d)(2) (42 U.S.C. 423(d)(2)) is amended—

- (1) in subparagraph (A), by striking "(except a widow, surviving divorced wife, widower, or surviving divorced husband for purposes of section 202(e) or (f))";
- (2) by striking subparagraph (B); and
- (3) by redesignating subparagraph (C) as subparagraph (B).

(b) **CONFORMING AMENDMENTS.**—

- (1) The third sentence of section 216(i)(1) (42 U.S.C. 416(i)(1)) is amended by striking "(2)(C)" and inserting "(2)(B)".
- (2) Section 223(f)(1)(B) (42 U.S.C. 423(f)(1)(B)) is amended to read as follows:

"(B) the individual is now able to engage in substantial gainful activity; or".

- (3) Section 223(f)(2)(A)(ii) (42 U.S.C. 423(f)(2)(A)(ii)) is amended to read as follows:

"(ii) the individual is now able to engage in substantial gainful activity, or".

- (4) Section 223(f)(3) (42 U.S.C. 423(f)(3)) is amended by striking "therefore—" and all that follows and inserting "therefore the individual is able to engage in substantial gainful activity; or".

(5) Section 223(f) is further amended, in the matter following paragraph (4), by striking "(or gainful activity in the case of a widow, surviving divorced wife, widower, or surviving divorced husband)" each place it appears.

(c) **TRANSITIONAL RULES RELATING TO MEDICAID AND MEDICARE ELIGIBILITY.**—

- (1) **DETERMINATION OF MEDICAID ELIGIBILITY.**—Section 1634(d) (42 U.S.C. 1383c(d)) is amended—

(A) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(B) by striking "(d) If any person—" and inserting "(d)(1) This subsection applies with respect to any person who—";

(C) in subparagraph (A) (as redesignated), by striking "as required" and all that follows through "but not entitled" and inserting "being then not entitled";

(D) in subparagraph (B) (as redesignated), by striking "section 1616(a)," and inserting "section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66)."; and

(E) by striking "such person shall" and all that follows and inserting the following new paragraph:

"(2) For purposes of title XIX, each person with respect to whom this subsection applies—

"(A) shall be deemed to be a recipient of supplemental security income benefits under this title if such person received such a benefit for the month before the month in which such person began to receive a benefit described in paragraph (1)(A), and

"(B) shall be deemed to be a recipient of State supplementary payments of the type referred to in section 1616(a) of this Act (or payments of the type described in section 212(a) of Public Law 93-66) if such person received such a payment for the month before the month in which such person began to receive a benefit described in paragraph (1)(A),
for so long as such person (i) would be eligible for such supplemental security income benefits, or such State supplementary payments (or payments of the type described in section 212(a) of Public Law 93-66), in the absence of benefits described in paragraph (1)(A), and (ii) is not entitled to hospital insurance benefits under part A of title XVIII."

(2) INCLUSION OF MONTHS OF SSI ELIGIBILITY WITHIN 5-MONTH DISABILITY WAITING PERIOD AND 24-MONTH MEDICARE WAITING PERIOD.—

(A) WIDOW'S BENEFITS BASED ON DISABILITY.—Section 202(e)(5) (42 U.S.C. 402(e)(5)) is amended—

(i) in subparagraph (B), by striking "(i)" and "(ii)" and inserting "(I)" and "(II)", respectively;

(ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(iii) by inserting "(A)" after "(5)"; and

(iv) by adding at the end the following new subparagraph:

"(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widow or surviving divorced wife is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met."

(B) WIDOWER'S BENEFITS BASED ON DISABILITY.—Section 202(f)(6) (42 U.S.C. 402(f)(6)) is amended—

- (i) in subparagraph (B), by striking "(i)" and "(ii)" and inserting "(I)" and "(II)", respectively;
- (ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;
- (iii) by inserting "(A)" after "(6)"; and
- (iv) by adding at the end the following new subparagraph:

"(B) For purposes of paragraph (1)(F)(i), each month in the period commencing with the first month for which such widower or surviving divorced husband is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), shall be included as one of the months of such waiting period for which the requirements of subparagraph (A) have been met."

(C) **MEDICARE BENEFITS.**—Section 226(e)(1) (42 U.S.C. 426(e)(1)) is amended—

- (i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;
- (ii) by inserting "(A)" after "(e)(1)"; and
- (iii) by adding at the end the following new subparagraph:

"(B) For purposes of subsection (b)(2)(A)(iii), each month in the period commencing with the first month for which an individual is first eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) of this Act (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), shall be included as one of the 24 months for which such individual must have been entitled to widow's or widower's insurance benefits on the basis of disability in order to become entitled to hospital insurance benefits on that basis."

(d) **DEEMED DISABILITY FOR PURPOSES OF ENTITLEMENT TO WIDOW'S AND WIDOWER'S INSURANCE BENEFITS FOR WIDOWS AND WIDOWERS ON SSI ROLLS.**—

(1) **WIDOW'S INSURANCE BENEFITS.**—Section 202(e) (42 U.S.C. 402(e)) is amended by adding at the end the following new paragraph:

"(9) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in section 1616(a) (or in section 212(b) of Public Law 93-66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met."

(2) **WIDOWER'S INSURANCE BENEFITS.**—Section 202(f) (42 U.S.C. 402(f)) is amended by adding at the end the following new paragraph:

"(9) An individual shall be deemed to be under a disability for purposes of paragraph (1)(B)(ii) if such individual is eligible for supplemental security income benefits under title XVI, or State supplementary payments of the type referred to in section 1616(a) (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in such section 1616(a) (or in section 212(b) of Public Law 93-66), for the month for which all requirements of paragraph (1) for entitlement to benefits under this subsection (other than being under a disability) are met."

(e) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—The amendments made by this section (other than paragraphs (1) and (2)(C) of subsection (c)) shall apply with respect to monthly insurance benefits for months after December 1990 for which applications are filed on or after January 1, 1991, or are pending on such date. The amendments made by subsection (c)(1) shall apply with respect to medical assistance provided after December 1990. The amendments made by subsection (c)(2)(C) shall apply with respect to items and services furnished after December 1990.

(2) **APPLICATION REQUIREMENTS FOR CERTAIN INDIVIDUALS ON BENEFIT ROLLS.**—In the case of any individual who—

(A) is entitled to disability insurance benefits under section 223 of the Social Security Act for December 1990 or is eligible for supplemental security income benefits under title XVI of such Act, or State supplementary payments of the type referred to in section 1616(a) of such Act (or payments of the type described in section 212(a) of Public Law 93-66) which are paid by the Secretary under an agreement referred to in such section 1616(a) (or in section 212(b) of Public Law 93-66), for January 1991,

(B) applied for widow's or widower's insurance benefits under subsection (e) or (f) of section 202 of the Social Security Act during 1990, and

(C) is not entitled to such benefits under such subsection (e) or (f) for any month on the basis of such application by reason of the definition of disability under section 223(d)(2)(B) of the Social Security Act (as in effect immediately before the date of the enactment of this Act), and would have been so entitled for such month on the basis of such application if the amendments made by this section had been applied with respect to such application, for purposes of determining such individual's entitlement to such benefits under subsection (e) or (f) of section 202 of the Social Security Act for months after December 1990, the requirement of paragraph (1)(C)(i) of such subsection shall be deemed to have been met.

SEC. 5104. DEPENDENCY REQUIREMENTS APPLICABLE TO A CHILD ADOPTED BY A SURVIVING SPOUSE.

(a) **IN GENERAL.**—Section 216(e) (42 U.S.C. 416(e)) is amended in the second sentence—

(1) by striking "at the time of such individual's death living in such individual's household" and inserting "either living

with or receiving at least one-half of his support from such individual at the time of such individual's death"; and

(2) by striking "; except" and all that follows and inserting a period.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits payable for months after December 1990, but only on the basis of applications filed after December 31, 1990.

SEC. 5105. REPRESENTATIVE PAYEE REFORMS.

(a) **IMPROVEMENTS IN THE REPRESENTATIVE PAYEE SELECTION AND RECRUITMENT PROCESS.**—

(1) **AUTHORITY FOR CERTIFICATION OF PAYMENTS TO REPRESENTATIVE PAYEES.**—

(A) **TITLE II.**—Section 205(j)(1) (42 U.S.C. 405(j)) is amended to read as follows:

"REPRESENTATIVE PAYEES

"(j)(1) If the Secretary determines that the interest of any individual under this title would be served thereby, certification of payment of such individual's benefit under this title may be made, regardless of the legal competency or incompetency of the individual, either for direct payment to the individual, or for his or her use and benefit, to another individual, or an organization, with respect to whom the requirements of paragraph (2) have been met (hereinafter in this subsection referred to as the individual's 'representative payee'). If the Secretary or a court of competent jurisdiction determines that a representative payee has misused any individual's benefit paid to such representative payee pursuant to this subsection or section 1631(a)(2), the Secretary shall promptly revoke certification for payment of benefits to such representative payee pursuant to this subsection and certify payment to an alternative representative payee or to the individual."

(B) **TITLE XVI.**—

(i) **IN GENERAL.**—Section 1631(a)(2)(A) (42 U.S.C. 1383(a)(2)(A)) is amended to read as follows:

"(A)(i) Payments of the benefit of any individual may be made to any such individual or to the eligible spouse (if any) of such individual or partly to each.

"(ii) Upon a determination by the Secretary that the interest of such individual would be served thereby, or in the case of any individual or eligible spouse referred to in section 1611(e)(3)(A), such payments shall be made, regardless of the legal competency or incompetency of the individual or eligible spouse, to another individual, or an organization, with respect to whom the requirements of subparagraph (B) have been met (in this paragraph referred to as such individual's 'representative payee') for the use and benefit of the individual or eligible spouse.

"(iii) If the Secretary or a court of competent jurisdiction determines that the representative payee of an individual or eligible spouse has misused any benefits which have been paid to the representative payee pursuant to clause (ii) or section 205(j)(1), the Secretary shall promptly terminate payment of benefits to the representative payee pursuant to this subparagraph, and provide for payment

of benefits to the individual or eligible spouse or to an alternative representative payee of the individual or eligible spouse.”.

(ii) CONFORMING AMENDMENTS.—Section 1631(a)(2)(C) (42 U.S.C. 1383(a)(2)(C)) is amended—

(I) in clause (i), by striking “a person other than the individual or spouse entitled to such payment” and inserting “representative payee of an individual or spouse”;

(II) in clauses (ii), (iii), and (iv), by striking “other person to whom such payment is made” each place it appears and inserting “representative payee”; and

(III) in clause (v)—

(aa) by striking “person receiving payments on behalf of another” and inserting “representative payee”; and

(bb) by striking “person receiving such payments” and inserting “representative payee”.

(2) PROCEDURE FOR SELECTING REPRESENTATIVE PAYEES.—

(A) IN GENERAL.—

(i) TITLE II.—Section 205(j)(2) (42 U.S.C. 405(j)(2)) is amended to read as follows:

“(2)(A) Any certification made under paragraph (1) for payment of benefits to an individual’s representative payee shall be made on the basis of—

“(i) an investigation by the Secretary of the person to serve as representative payee, which shall be conducted in advance of such certification and shall, to the extent practicable, include a face-to-face interview with such person, and

“(ii) adequate evidence that such certification is in the interest of such individual (as determined by the Secretary in regulations).

“(B)(i) As part of the investigation referred to in subparagraph (A)(i), the Secretary shall—

“(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity has been submitted with an application for benefits under this title or title XVI,

“(II) verify such person’s social security account number (or employer identification number),

“(III) determine whether such person has been convicted of a violation of section 208 or 1632, and

“(IV) determine whether certification of payment of benefits to such person has been revoked pursuant to this subsection or payment of benefits to such person has been terminated pursuant to section 1631(a)(2)(A)(iii) by reason of misuse of funds paid as benefits under this title or title XVI.

“(ii) The Secretary shall establish and maintain a centralized file, which shall be updated periodically and which shall be in a form which renders it readily retrievable by each servicing office of the Social Security Administration. Such file shall consist of—

“(I) a list of the names and social security account numbers (or employer identification numbers) of all persons with respect to whom certification of payment of benefits has been revoked

on or after January 1, 1991, pursuant to this subsection, or with respect to whom payment of benefits has been terminated on or after such date pursuant to section 1631(a)(2)(A)(iii), by reason of misuse of funds paid as benefits under this title or title XVI, and

"(II) a list of the names and social security account numbers (or employer identification numbers) of all persons who have been convicted of a violation of section 208 or 1632.

"(C)(i) Benefits of an individual may not be certified for payment to any other person pursuant to this subsection if—

"(I) such person has previously been convicted as described in subparagraph (B)(i)(III),

"(II) except as provided in clause (ii), certification of payment of benefits to such person under this subsection has previously been revoked as described in subparagraph (B)(i)(IV), or payment of benefits to such person pursuant to section 1631(a)(2)(A)(ii) has previously been terminated as described in section 1631(a)(2)(B)(ii)(IV), or

"(III) except as provided in clause (iii), such person is a creditor of such individual who provides such individual with goods or services for consideration.

"(ii) The Secretary shall prescribe regulations under which the Secretary may grant exemptions to any person from the provisions of clause (i)(II) on a case-by-case basis if such exemption is in the best interest of the individual whose benefits would be paid to such person pursuant to this subsection.

"(iii) Clause (i)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

"(I) a relative of such individual if such relative resides in the same household as such individual,

"(II) a legal guardian or legal representative of such individual,

"(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State,

"(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the certification of payment to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee to whom such certification of payment would serve the best interests of such individual, or

"(V) an individual who is determined by the Secretary, on the basis of written findings and under procedures which the Secretary shall prescribe by regulation, to be acceptable to serve as a representative payee.

"(iv) The procedures referred to in clause (iii)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Secretary, that—

"(I) such individual poses no risk to the beneficiary,

"(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest, and

"(III) no other more suitable representative payee can be found.

“(D)(i) Subject to clause (ii), if the Secretary makes a determination described in the first sentence of paragraph (1) with respect to any individual’s benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Secretary may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subsection.

“(i)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (i) shall be for a period of not more than 1 month.

“(II) Subclause (I) shall not apply in any case in which the individual is, as of the date of the Secretary’s determination, legally incompetent or under the age of 15.

“(iii) Payment pursuant to this subsection of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual or the representative payee as a single sum or over such period of time as the Secretary determines is in the best interest of the individual entitled to such benefits.

“(E)(i) Any individual who is dissatisfied with a determination by the Secretary to certify payment of such individual’s benefit to a representative payee under paragraph (1) or with the designation of a particular person to serve as representative payee shall be entitled to a hearing by the Secretary to the same extent as is provided in subsection (b), and to judicial review of the Secretary’s final decision as is provided in subsection (g).

“(ii) In advance of the certification of payment of an individual’s benefit to a representative payee under paragraph (1), the Secretary shall provide written notice of the Secretary’s initial determination to certify such payment. Such notice shall be provided to such individual, except that, if such individual—

“(I) is under the age of 15,

“(II) is an unemancipated minor under the age of 18, or

“(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

“(iii) Any notice described in clause (ii) shall be clearly written in language that is easily understandable to the reader, shall identify the person to be designated as such individual’s representative payee, and shall explain to the reader the right under clause (i) of such individual or of such individual’s legal guardian or legal representative—

“(I) to appeal a determination that a representative payee is necessary for such individual,

“(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

“(III) to review the evidence upon which such designation is based and submit additional evidence.”

(ii) TITLE XVI.—Section 1631(a)(2)(B) (42 U.S.C. 1383(a)(2)(B)) is amended to read as follows:

“(B)(i) Any determination made under subparagraph (A) for payment of benefits to the representative payee of an individual or eligible spouse shall be made on the basis of—

"(I) an investigation by the Secretary of the person to serve as representative payee, which shall be conducted in advance of such payment, and shall, to the extent practicable, include a face-to-face interview with such person; and

"(II) adequate evidence that such payment is in the interest of the individual or eligible spouse (as determined by the Secretary in regulations).

"(ii) As part of the investigation referred to in clause (i)(I), the Secretary shall—

"(I) require the person being investigated to submit documented proof of the identity of such person, unless information establishing such identity was submitted with an application for benefits under title II or this title;

"(II) verify the social security account number (or employer identification number) of such person;

"(III) determine whether such person has been convicted of a violation of section 208 or 1632; and

"(IV) determine whether payment of benefits to such person has been terminated pursuant to subparagraph (A)(iii), and whether certification of payment of benefits to such person has been revoked pursuant to section 205(j), by reason of misuse of funds paid as benefits under title II or this title.

"(iii) Benefits of an individual may not be paid to any other person pursuant to subparagraph (A)(ii) if—

"(I) such person has previously been convicted as described in clause (ii)(III);

"(II) except as provided in clause (iv), payment of benefits to such person pursuant to subparagraph (A)(ii) has previously been terminated as described in clause (ii)(IV), or certification of payment of benefits to such person under section 205(j) has previously been revoked as described in section 205(j)(2)(B)(i)(IV); or

"(III) except as provided in clause (v), such person is a creditor of such individual who provides such individual with goods or services for consideration.

"(iv) The Secretary shall prescribe regulations under which the Secretary may grant an exemption from clause (iii)(II) to any person on a case-by-case basis if such exemption would be in the best interest of the individual or eligible spouse whose benefits under this title would be paid to such person pursuant to subparagraph (A)(ii).

"(v) Clause (iii)(III) shall not apply with respect to any person who is a creditor referred to therein if such creditor is—

"(I) a relative of such individual if such relative resides in the same household as such individual;

"(II) a legal guardian or legal representative of such individual;

"(III) a facility that is licensed or certified as a care facility under the law of a State or a political subdivision of a State;

"(IV) a person who is an administrator, owner, or employee of a facility referred to in subclause (III) if such individual resides in such facility, and the payment of benefits under this title to such facility or such person is made only after good faith efforts have been made by the local servicing office of the Social Security Administration to locate an alternative representative payee

to whom the payment of such benefits would serve the best interests of such individual; or

“(V) an individual who is determined by the Secretary, on the basis of written findings and under procedures which the Secretary shall prescribe by regulation, to be acceptable to serve as a representative payee.

“(vi) The procedures referred to in clause (v)(V) shall require the individual who will serve as representative payee to establish, to the satisfaction of the Secretary, that—

“(I) such individual poses no risk to the beneficiary;

“(II) the financial relationship of such individual to the beneficiary poses no substantial conflict of interest; and

“(III) no other more suitable representative payee can be found.

“(vii) Subject to clause (viii), if the Secretary makes a determination described in subparagraph (A)(ii) with respect to any individual's benefit and determines that direct payment of the benefit to the individual would cause substantial harm to the individual, the Secretary may defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made pursuant to this subparagraph.

“(viii)(I) Except as provided in subclause (II), any deferral or suspension of direct payment of a benefit pursuant to clause (vii) shall be for a period of not more than 1 month.

“(II) Subclause (I) shall not apply in any case in which the individual or eligible spouse is, as of the date of the Secretary's determination, legally incompetent, under the age 15 years, or a drug addict or alcoholic referred to in section 1611(e)(3)(A).

“(ix) Payment pursuant to this subparagraph of any benefits which are deferred or suspended pending the selection of a representative payee shall be made to the individual, or to the representative payee upon such selection, as a single sum or over such period of time as the Secretary determines is in the best interests of the individual entitled to such benefits.

“(x) Any individual who is dissatisfied with a determination by the Secretary to pay such individual's benefits to a representative payee under this title, or with the designation of a particular person to serve as representative payee, shall be entitled to a hearing by the Secretary, and to judicial review of the Secretary's final decision, to the same extent as is provided in subsection (c).

“(xi) In advance of the first payment of an individual's benefit to a representative payee under subparagraph (A)(ii), the Secretary shall provide written notice of the Secretary's initial determination to make any such payment. Such notice shall be provided to such individual, except that, if such individual—

“(I) is under the age of 15,

“(II) is an unemancipated minor under the age of 18, or

“(III) is legally incompetent,

then such notice shall be provided solely to the legal guardian or legal representative of such individual.

“(xii) Any notice described in clause (xi) shall be clearly written in language that is easily understandable to the reader, shall iden-

tify the person to be designated as such individual's representative payee, and shall explain to the reader the right under clause (x) of such individual or of such individual's legal guardian or legal representative—

“(I) to appeal a determination that a representative payee is necessary for such individual,

“(II) to appeal the designation of a particular person to serve as the representative payee of such individual, and

“(III) to review the evidence upon which such designation is based and submit additional evidence.”

(B) **REPORT ON FEASIBILITY OF OBTAINING READY ACCESS TO CERTAIN CRIMINAL FRAUD RECORDS.**—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Attorney General of the United States and the Secretary of the Treasury, shall study the feasibility of establishing and maintaining a current list, which would be readily available to local offices of the Social Security Administration for use in investigations undertaken pursuant to section 205(j)(2) or 1631(a)(2)(B) of the Social Security Act, of the names and social security account numbers of individuals who have been convicted of a violation of section 495 of title 18, United States Code. The Secretary of Health and Human Services shall, not later than July 1, 1992, submit the results of such study, together with any recommendations, to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

(3) **PROVISION FOR COMPENSATION OF QUALIFIED ORGANIZATIONS SERVING AS REPRESENTATIVE PAYEES.**—

(A) **IN GENERAL.**—

(i) **TITLE II.**—Section 205(j) (42 U.S.C. 405(j)) is amended by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

“(4)(A) A qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to this subsection if such fee does not exceed the lesser of—

“(i) 10 percent of the monthly benefit involved, or

“(ii) \$25.00 per month.

Any agreement providing for a fee in excess of the amount permitted under this subparagraph shall be void and shall be treated as misuse by such organization of such individual's benefits.

“(B) For purposes of this paragraph, the term ‘qualified organization’ means any community-based nonprofit social service agency which is bonded or licensed in each State in which it serves as a representative payee and which, in accordance with any applicable regulations of the Secretary—

“(i) regularly provides services as the representative payee, pursuant to this subsection or section 1631(a)(2), concurrently to 5 or more individuals,

"(ii) demonstrates to the satisfaction of the Secretary that such agency is not otherwise a creditor of any such individual, and

"(iii) was in existence on October 1, 1988.

The Secretary shall prescribe regulations under which the Secretary may grant an exception from clause (ii) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

"(C) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under subparagraph (A) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee, shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

"(D) This paragraph shall cease to be effective on July 1, 1994."

(ii) TITLE XVI.—Section 1631(a)(2) (42 U.S.C. 1383(a)(2)) is amended—

(I) by redesignating subparagraph (D) as subparagraph (E);

(II) by inserting after subparagraph (C) the following:

"(D)(i) A qualified organization may collect from an individual a monthly fee for expenses (including overhead) incurred by such organization in providing services performed as such individual's representative payee pursuant to subparagraph (A)(ii) if the fee does not exceed the lesser of—

"(I) 10 percent of the monthly benefit involved, or

"(II) \$25.00 per month.

Any agreement providing for a fee in excess of the amount permitted under this clause shall be void and shall be treated as misuse by the organization of such individual's benefits.

"(ii) For purposes of this subparagraph, the term 'qualified organization' means any community-based nonprofit social service agency which—

"(I) is bonded or licensed in each State in which the agency serves as a representative payee;

"(II) in accordance with any applicable regulations of the Secretary—

"(aa) regularly provides services as a representative payee pursuant to subparagraph (A)(ii) or section 205(j)(4) concurrently to 5 or more individuals;

"(bb) demonstrates to the satisfaction of the Secretary that such agency is not otherwise a creditor of any such individual; and

"(cc) was in existence on October 1, 1988.

The Secretary shall prescribe regulations under which the Secretary may grant an exception from subclause (II)(bb) for any individual on a case-by-case basis if such exception is in the best interests of such individual.

"(iii) Any qualified organization which knowingly charges or collects, directly or indirectly, any fee in excess of the maximum fee prescribed under clause (i) or makes any agreement, directly or indirectly, to charge or collect any fee in excess of such maximum fee,

shall be fined in accordance with title 18, United States Code, or imprisoned not more than 6 months, or both.

^(iv) This subparagraph shall cease to be effective on July 1, 1994."

(B) STUDIES AND REPORTS.—

(i) REPORT BY SECRETARY OF HEALTH AND HUMAN SERVICES.—Not later than January 1, 1993, the Secretary of Health and Human Services shall transmit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate setting forth the number and types of qualified organizations which have served as representative payees and have collected fees for such service pursuant to any amendment made by subparagraph (A).

(ii) REPORT BY COMPTROLLER GENERAL.—Not later than July 1, 1992, the Comptroller General of the United States shall conduct a study of the advantages and disadvantages of allowing qualified organizations serving as representative payees to charge fees pursuant to the amendments made by subparagraph (A) and shall transmit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate setting forth the results of such study.

(4) STUDY RELATING TO FEASIBILITY OF SCREENING OF INDIVIDUALS WITH CRIMINAL RECORDS.—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct a study of the feasibility of determining the type of representative payee applicant most likely to have a felony or misdemeanor conviction, the suitability of individuals with prior convictions to serve as representative payees, and the circumstances under which such applicants could be allowed to serve as representative payees. The Secretary shall transmit the results of such study to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate not later than July 1, 1992.

(5) EFFECTIVE DATES.—

(A) USE AND SELECTION OF REPRESENTATIVE PAYEES.—The amendments made by paragraphs (1) and (2) shall take effect July 1, 1991, and shall apply only with respect to—

(i) certifications of payment of benefits under title II of the Social Security Act to representative payees made on or after such date; and

(ii) provisions for payment of benefits under title XVI of such Act to representative payees made on or after such date.

(B) COMPENSATION OF REPRESENTATIVE PAYEES.—The amendments made by paragraph (3) shall take effect July 1, 1991, and the Secretary of Health and Human Services shall prescribe initial regulations necessary to carry out such amendments not later than such date.

(b) IMPROVEMENTS IN RECORDKEEPING AND AUDITING REQUIREMENTS.—

(1) *IMPROVED ACCESS TO CERTAIN INFORMATION.*—

(A) *IN GENERAL.*—Section 205(j)(3) (42 U.S.C. 605(j)(3)) is amended—

- (i) by striking subparagraph (B);
- (ii) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (B), (C), and (D), respectively;
- (iii) in subparagraph (D) (as so redesignated), by striking “(A), (B), (C), and (D)” and inserting “(A), (B), and (C)”; and
- (iv) by adding at the end the following new subparagraphs:

“(E) The Secretary shall maintain a centralized file, which shall be updated periodically and which shall be in a form which will be readily retrievable by each servicing office of the Social Security Administration, of—

“(i) the address and the social security account number (or employer identification number) of each representative payee who is receiving benefit payments pursuant to this subsection or section 1631(a)(2), and

“(ii) the address and social security account number of each individual for whom each representative payee is reported to be providing services as representative payee pursuant to this subsection or section 1631(a)(2).”

“(F) Each servicing office of the Administration shall maintain a list, which shall be updated periodically, of public agencies and community-based nonprofit social service agencies which are qualified to serve as representative payees pursuant to this subsection or section 1631(a)(2) and which are located in the area served by such servicing office.”

(B) *EFFECTIVE DATE.*—The amendments made by subparagraph (A) shall take effect October 1, 1992, and the Secretary of Health and Human Services shall take such actions as are necessary to ensure that the requirements of section 205(j)(3)(E) of the Social Security Act (as amended by subparagraph (A) of this paragraph) are satisfied as of such date.

(2) *STUDY RELATING TO MORE STRINGENT OVERSIGHT OF HIGH-RISK REPRESENTATIVE PAYEES.*—

(A) *IN GENERAL.*—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct a study of the need for a more stringent accounting system for high-risk representative payees than is otherwise generally provided under section 205(j)(3) or 1631(a)(2)(C) of the Social Security Act, which would include such additional reporting requirements, record maintenance requirements, and other measures as the Secretary considers necessary to determine whether services are being appropriately provided by such payees in accordance with such sections 205(j) and 1631(a)(2).

(B) *SPECIAL PROCEDURES.*—In such study, the Secretary shall determine the appropriate means of implementing more stringent, statistically valid procedures for—

(i) reviewing reports which would be submitted to the Secretary under any system described in subparagraph (A), and

(ii) periodic, random audits of records which would be kept under such a system,
in order to identify any instances in which high-risk representative payees are misusing payments made pursuant to section 205(j) or 1631(a)(2) of the Social Security Act.

(C) **HIGH-RISK REPRESENTATIVE PAYEE.**—For purposes of this paragraph, the term “high-risk representative payee” means a representative payee under section 205(j) or 1631(a)(2) of the Social Security Act (42 U.S.C. 405(j) and 1383(a)(2), respectively) (other than a Federal or State institution) who—

(i) regularly provides concurrent services as a representative payee under such section 205(j), such section 1631(a)(2), or both such sections, for 5 or more individuals who are unrelated to such representative payee,

(ii) is neither related to an individual on whose behalf the payee is being paid benefits nor living in the same household with such individual,

(iii) is a creditor of such individual, or

(iv) is in such other category of payees as the Secretary may determine appropriate.

(D) **REPORT.**—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, together with any recommendations, not later than July 1, 1992. Such report shall include an evaluation of the feasibility and desirability of legislation implementing stricter accounting and review procedures for high-risk representative payees in all servicing offices of the Social Security Administration (together with proposed legislative language).

(3) **DEMONSTRATION PROJECTS RELATING TO PROVISION OF INFORMATION TO LOCAL AGENCIES PROVIDING CHILD AND ADULT PROTECTIVE SERVICES.**—

(A) **IN GENERAL.**—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall implement a demonstration project under this paragraph in all or part of not fewer than 2 States. Under each such project, the Secretary shall enter into an agreement with the State in which the project is located to make readily available, for the duration of the project, to the appropriate State agency, a listing of addresses of multiple benefit recipients.

(B) **LISTING OF ADDRESSES OF MULTIPLE BENEFIT RECIPIENTS.**—The list referred to in subparagraph (A) shall consist of a current list setting forth each address within the State at which benefits under title II, benefits under title XVI, or any combination of such benefits are being received by 5 or more individuals. For purposes of this subparagraph, in the case of benefits under title II, all individuals receiving benefits on the basis of the wages and self-employ-

ment income of the same individual shall be counted as 1 individual.

(C) **APPROPRIATE STATE AGENCY.**—The appropriate State agency referred to in subparagraph (A) is the agency of the State which the Secretary determines is primarily responsible for regulating care facilities operated in such State or providing for child and adult protective services in such State.

(D) **REPORT.**—The Secretary shall report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate concerning such demonstration projects, together with any recommendations, not later than July 1, 1992. Such report shall include an evaluation of the feasibility and desirability of legislation implementing the programs established pursuant to this paragraph on a permanent basis.

(E) **STATE.**—For purposes of this paragraph, the term "State" means a State, including the entities included in such term by section 210(h) of the Social Security Act (42 U.S.C. 410(h)).

(c) **RESTITUTION.**—

(1) **TITLE II.**—Section 205(j) (42 U.S.C. 405(j)) is amended by redesignating paragraph (5) (as so redesignated by subsection (a)(3)(A)(i) of this section) as paragraph (6) and by inserting after paragraph (4) (as added by subsection (a)(3)(A)(i)) the following new paragraph:

"(5) In cases where the negligent failure of the Secretary to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Secretary shall certify for payment to the beneficiary or the beneficiary's alternative representative payee an amount equal to such misused benefits. The Secretary shall make a good faith effort to obtain restitution from the terminated representative payee."

(2) **TITLE XVI.**—Section 1631(a)(2) (42 U.S.C. 1383(a)(2)) is amended by redesignating subparagraph (E) (as so redesignated by subsection (a)(3)(A)(ii)(I) of this section) as subparagraph (F) and by inserting after subparagraph (D) (as added by subsection (a)(3)(A)(i)(III)) the following new subparagraph:

"(E) **RESTITUTION.**—In cases where the negligent failure of the Secretary to investigate or monitor a representative payee results in misuse of benefits by the representative payee, the Secretary shall make payment to the beneficiary or the beneficiary's representative payee of an amount equal to such misused benefits. The Secretary shall make a good faith effort to obtain restitution from the terminated representative payee."

(d) **REPORTS TO THE CONGRESS.**—

(1) **IN GENERAL.**—

(A) **TITLE II.**—Section 205(j)(5) (as so redesignated by subsection (c)(1) of this section) is amended to read as follows:

"(5) The Secretary shall include as a part of the annual report required under section 704 information with respect to the implementation of the preceding provisions of this subsection, including the number of cases in which the representative payee was changed, the number of cases discovered where there has been a misuse of funds,

how any such cases were dealt with by the Secretary, the final disposition of such cases, including any criminal penalties imposed, and such other information as the Secretary determines to be appropriate."

(B) *TITLE XVI.—Section 1631(a)(2)(E) (42 U.S.C. 1383(a)(2)(E)), as so redesignated by subsection (c)(2) of this section, is amended to read as follows:*

"(E) The Secretary shall include as a part of the annual report required under section 704 information with respect to the implementation of the preceding provisions of this paragraph, including—

"(i) the number of cases in which the representative payee was charged;

"(ii) the number of cases discovered where there has been a misuse of funds;

"(iii) how any such cases were dealt with by the Secretary;

"(iv) the final disposition of such cases (including any criminal penalties imposed); and

"(v) such other information as the Secretary determines to be appropriate."

(2) *EFFECTIVE DATE.*—The amendments made by paragraph (1) shall apply with respect to annual reports issued for years after 1991.

(3) *FEASIBILITY STUDY REGARDING INVOLVEMENT OF DEPARTMENT OF VETERANS AFFAIRS.*—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services, in cooperation with the Secretary of Veterans Affairs, shall conduct a study of the feasibility of designating the Department of Veterans Affairs as the lead agency for purposes of selecting, appointing, and monitoring representative payees for those individuals who receive benefits paid under title II or XVI of the Social Security Act and benefits paid by the Department of Veterans Affairs. Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall transmit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report setting forth the results of such study, together with any recommendations.

SEC. 5106. FEES FOR REPRESENTATION OF CLAIMANTS IN ADMINISTRATIVE PROCEEDINGS.

(a) *IN GENERAL.*—

(1) *TITLE II.*—Subsection (a) of section 206 (42 U.S.C. 406(a)) is amended—

(A) by inserting "(1)" after "(a)";

(B) in the fifth sentence, by striking "Whenever" and inserting "Except as provided in paragraph (2)(A), whenever"; and

(C) by striking the sixth sentence and all that follows through "Any person who" in the seventh sentence and inserting the following:

"(2)(A) In the case of a claim of entitlement to past-due benefits under this title, if—

"(i) an agreement between the claimant and another person regarding any fee to be recovered by such person to compensate such person for services with respect to the claim is presented in writing to the Secretary prior to the time of the Secretary's determination regarding the claim,

"(ii) the fee specified in the agreement does not exceed the lesser of—

"(I) 25 percent of the total amount of such past-due benefits (as determined before any applicable reduction under section 1127(a)), or

"(II) \$4,000, and

"(iii) the determination is favorable to the claimant,

then the Secretary shall approve that agreement at the time of the favorable determination, and (subject to paragraph (3)) the fee specified in the agreement shall be the maximum fee. The Secretary may from time to time increase the dollar amount under clause (ii)(II) to the extent that the rate of increase in such amount, as determined over the period since January 1, 1991, does not at any time exceed the rate of increase in primary insurance amounts under section 215(i) since such date. The Secretary shall publish any such increased amount in the Federal Register.

"(B) For purposes of this subsection, the term 'past-due benefits' excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 223.

"(C) In the case of a claim with respect to which the Secretary has approved an agreement pursuant to subparagraph (A), the Secretary shall provide the claimant and the person representing the claimant a written notice of—

"(i) the dollar amount of the past-due benefits (as determined before any applicable reduction under section 1127(a)) and the dollar amount of the past-due benefits payable to the claimant,

"(ii) the dollar amount of the maximum fee which may be charged or recovered as determined under this paragraph, and

"(iii) a description of the procedures for review under paragraph (3).

"(3)(A) The Secretary shall provide by regulation for review of the amount which would otherwise be the maximum fee as determined under paragraph (2) if, within 15 days after receipt of the notice provided pursuant to paragraph (2)(C)—

"(i) the claimant, or the administrative law judge or other adjudicator who made the favorable determination, submits a written request to the Secretary to reduce the maximum fee, or

"(ii) the person representing the claimant submits a written request to the Secretary to increase the maximum fee.

Any such review shall be conducted after providing the claimant, the person representing the claimant, and the adjudicator with reasonable notice of such request and an opportunity to submit written information in favor of or in opposition to such request. The adjudicator may request the Secretary to reduce the maximum fee only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest or on the basis of evidence that the fee is clearly excessive for services rendered.

"(B)(i) In the case of a request for review under subparagraph (A) by the claimant or by the person representing the claimant, such review shall be conducted by the administrative law judge who made the favorable determination or, if the Secretary determines that such administrative law judge is unavailable or if the determination was not made by an administrative law judge, such review shall be conducted by another person designated by the Secretary for such purpose.

"(ii) In the case of a request by the adjudicator for review under subparagraph (A), the review shall be conducted by the Secretary or by an administrative law judge or other person (other than such adjudicator) who is designated by the Secretary.

"(C) Upon completion of the review, the administrative law judge or other person conducting the review shall affirm or modify the amount which would otherwise be the maximum fee. Any such amount so affirmed or modified shall be considered the amount of the maximum fee which may be recovered under paragraph (2). The decision of the administrative law judge or other person conducting the review shall not be subject to further review.

"(4)(A) Subject to subparagraph (B), if the claimant is determined to be entitled to past-due benefits under this title and the person representing the claimant is an attorney, the Secretary shall, notwithstanding section 205(i), certify for payment out of such past-due benefits (as determined before any applicable reduction under section 1127(a)) to such attorney an amount equal to so much of the maximum fee as does not exceed 25 percent of such past-due benefits (as determined before any applicable reduction under section 1127(a)).

"(B) The Secretary shall not in any case certify any amount for payment to the attorney pursuant to this paragraph before the expiration of the 15-day period referred to in paragraph (3)(A) or, in the case of any review conducted under paragraph (3), before the completion of such review.

"(5) Any person who".

(2) TITLE XVI.—Paragraph (2)(A) of section 1631(d) (42 U.S.C. 1333(d)(2)(A)) is amended to read as follows:

"(2)(A) The provisions of section 206(a) (other than paragraph (4) thereof) shall apply to this part to the same extent as they apply in the case of title II, except that paragraph (2) thereof shall be applied—

"(i) by substituting 'section 1127(a) or 1631(g)' for 'section 1127(a)'; and

"(ii) by substituting 'section 1631(a)(7)(A) or the requirements of due process of law' for 'subsection (g) or (h) of section 223'."

(b) PROTECTION OF ATTORNEY'S FEES FROM OFFSETTING SSI BENEFITS.—Subsection (a) of section 1127 (42 U.S.C. 1320a-6(a)) is amended by adding at the end the following new sentence: "A benefit under title II shall not be reduced pursuant to the preceding sentence to the extent that any amount of such benefit would not otherwise be available for payment in full of the maximum fee which may be recovered from such benefit by an attorney pursuant to section 206(a)(4)."

(c) LIMITATION OF TRAVEL EXPENSES FOR REPRESENTATION OF CLAIMANTS AT ADMINISTRATIVE PROCEEDINGS.—Section 201(j) (42

U.S.C. 401(j)), section 1631(h) (42 U.S.C. 1383(h)), and section 1817(i) (42 U.S.C. 1395i(i)) are each amended by adding at the end the following new sentence: "The amount available for payment under this subsection for travel by a representative to attend an administrative proceeding before an administrative law judge or other adjudicator shall not exceed the maximum amount allowable under this subsection for such travel originating within the geographic area of the office having jurisdiction over such proceeding."

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after April 1, 1991.

SEC. 5107. APPLICABILITY OF ADMINISTRATIVE RES JUDICATA; RELATED NOTICE REQUIREMENTS.

(a) **IN GENERAL.**—

(1) **TITLE II.**—Section 205(b) (42 U.S.C. 405(b)) is amended by adding at the end the following new paragraph:

"(3)(A) A failure to timely request review of an initial adverse determination with respect to an application for any benefit under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any benefit under this title if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for benefits in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221.

"(B) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Secretary shall describe in clear and specific language the effect on possible entitlement to benefits under this title of choosing to reapply in lieu of requesting review of the determination."

(2) **TITLE XVI.**—Section 1631(c)(1) (42 U.S.C. 1383(c)(1)) is amended—

(A) by inserting "(A)" after "(c)(1)"; and

(B) by adding at the end the following:

"(B)(i) A failure to timely request review of an initial adverse determination with respect to an application for any payment under this title or an adverse determination on reconsideration of such an initial determination shall not serve as a basis for denial of a subsequent application for any payment under this title if the applicant demonstrates that the applicant, or any other individual referred to in paragraph (1), failed to so request such a review acting in good faith reliance upon incorrect, incomplete, or misleading information, relating to the consequences of reapplying for payments in lieu of seeking review of an adverse determination, provided by any officer or employee of the Social Security Administration or any State agency acting under section 221.

"(ii) In any notice of an adverse determination with respect to which a review may be requested under paragraph (1), the Secretary

shall describe in clear and specific language the effect on possible eligibility to receive payments under this title of choosing to reapply in lieu of requesting review of the determination."

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to adverse determinations made on or after July 1, 1991.

SEC. 5108. DEMONSTRATION PROJECTS RELATING TO ACCOUNTABILITY FOR TELEPHONE SERVICE CENTER COMMUNICATIONS.

(a) **IN GENERAL.**—The Secretary of Health and Human Services shall develop and carry out demonstration projects designed to implement the accountability procedures described in subsection (b) in each of not fewer than 3 telephone service centers operated by the Social Security Administration. Telephone service centers shall be selected for implementation of the accountability procedures so as to permit a thorough evaluation of such procedures as they would operate in conjunction with the service technology most recently employed by the Social Security Administration. Each such demonstration project shall commence not later than 180 days after the date of the enactment of this Act and shall remain in operation for not less than 1 year and not more than 3 years.

(b) **ACCOUNTABILITY PROCEDURES.**—

(1) **IN GENERAL.**—During the period of each demonstration project developed and carried out by the Secretary of Health and Human Services with respect to a telephone service center pursuant to subsection (a), the Secretary shall provide for the application at such telephone service center of accountability procedures consisting of the following:

(A) In any case in which a person communicates with the Social Security Administration by telephone at such telephone service center and provides in such communication his or her name, address, and such other identifying information as the Secretary determines necessary and appropriate for purposes of this subparagraph, the Secretary must thereafter promptly provide such person a written receipt which sets forth—

(i) the name of any individual representing the Social Security Administration with whom such person has spoken in such communication,

(ii) the date of the communication;

(iii) a description of the nature of the communication,

(iv) any action that an individual representing the Social Security Administration has indicated in the communication will be taken in response to the communication, and

(v) a description of the information or advice offered in the communication by an individual representing the Social Security Administration.

(B) Such person must be notified during the communication by an individual representing the Social Security Administration that, if adequate identifying information is provided to the Administration, a receipt described in subparagraph (A) will be provided to such person.

(C) A copy of any receipt required to be provided to any person under subparagraph (A) must be—

(i) included in the file maintained by the Social Security Administration relating to such person, or

(ii) if there is no such file, otherwise retained by the Social Security Administration in retrievable form until the end of the 5-year period following the termination of the project.

(2) *EXCLUSION OF CERTAIN ROUTINE TELEPHONE COMMUNICATIONS.*—The Secretary may exclude from demonstration projects carried out pursuant to this section routine telephone communications which do not relate to potential or current eligibility or entitlement to benefits.

(c) *REPORT.*—

(1) *IN GENERAL.*—The Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a written report on the progress of the demonstration projects conducted pursuant to this section, together with any related data and materials which the Secretary may consider appropriate. The report shall be submitted not later than 90 days after the termination of the project.

(2) *SPECIFIC MATTERS TO BE INCLUDED.*—The report required under paragraph (1) shall—

(A) assess the costs and benefits of the accountability procedures,

(B) identify any major difficulties encountered in implementing the demonstration project, and

(C) assess the feasibility of implementing the accountability procedures on a national basis.

SEC. 5109. NOTICE REQUIREMENTS.

(a) *REQUIREMENTS.*—

(1) *TITLE II.*—Section 205 (42 U.S.C. 405) is amended by inserting after subsection (r) the following new subsection:

“NOTICE REQUIREMENTS

“(s) The Secretary shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this title by the Secretary or by a State agency—

“(1) is written in simple and clear language, and

“(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached.”

(2) *TITLE XVI.*—Section 1631 (42 U.S.C. 1383) is amended by adding at the end the following:

"NOTICE REQUIREMENTS

"(n) The Secretary shall take such actions as are necessary to ensure that any notice to one or more individuals issued pursuant to this title by the Secretary or by a State agency—

"(1) is written in simple and clear language, and

"(2) includes the address and telephone number of the local office of the Social Security Administration which serves the recipient.

In the case of any such notice which is not generated by a local servicing office, the requirements of paragraph (2) shall be treated as satisfied if such notice includes the address of the local office of the Social Security Administration which services the recipient of the notice and a telephone number through which such office can be reached."

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to notices issued on or after July 1, 1991.

SEC. 5110. TELEPHONE ACCESS TO THE SOCIAL SECURITY ADMINISTRATION.

(a) **REQUIRED MINIMUM LEVEL OF ACCESS TO LOCAL OFFICES.**—In addition to such other access by telephone to offices of the Social Security Administration as the Secretary of Health and Human Services may consider appropriate, the Secretary shall maintain access by telephone to local offices of the Social Security Administration at the level of access generally available as of September 30, 1989.

(b) **TELEPHONE LISTINGS.**—The Secretary shall make such requests of local telephone utilities in the United States as are necessary to ensure that the listings subsequently maintained and published by such utilities for each locality include the address and telephone number for each local office of the Social Security Administration to which direct telephone access is maintained under subsection (a) in such locality. Such listing may also include information concerning the availability of a toll-free number which may be called for general information.

(c) **REPORT BY SECRETARY.**—Not later than January 1, 1993, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report which—

(1) assesses the impact of the requirements established by this section on the Social Security Administration's allocation of resources, workload levels, and service to the public, and

(2) presents a plan for using new, innovative technologies to enhance access to the Social Security Administration, including access to local offices.

(d) **GAO REPORT.**—The Comptroller General of the United States shall review the level of telephone access by the public to the local offices of the Social Security Administration. The Comptroller General shall file an interim report with the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate describing such level of telephone access not later than 120 days after the date of the enactment of this Act and shall file a final report with such Committees describing such level of access not later than 210 days after such date.

(e) **EFFECTIVE DATE.**—*The Secretary of Health and Human Services shall meet the requirements of subsections (a) and (b) as soon as possible after the date of the enactment of this Act but not later 180 days after such date.*

SEC. 5111. AMENDMENTS RELATING TO SOCIAL SECURITY ACCOUNT STATEMENTS.

(a) **IN GENERAL.**—*Section 1142 (42 U.S.C. 1320b-13), as added by section 10308 of the Omnibus Budget Reconciliation Act of 1989 (103 Stat. 2485), is amended—*

- (1) *by striking “SEC. 1142.” and inserting “SEC. 1143.”; and*
- (2) *in subsection (c)(2), by striking “a biennial” and inserting “an annual”.*

(b) **DISCLOSURE OF ADDRESS INFORMATION BY INTERNAL REVENUE SERVICE TO SOCIAL SECURITY ADMINISTRATION.**—

(1) **IN GENERAL.**—*Section 6103(m) of the Internal Revenue Code of 1986 (relating to disclosure of taxpayer identity information) is amended by adding at the end the following new paragraph:*

“(7) **SOCIAL SECURITY ACCOUNT STATEMENT FURNISHED BY SOCIAL SECURITY ADMINISTRATION.**—*Upon written request by the Commissioner of Social Security, the Secretary may disclose the mailing address of any taxpayer who is entitled to receive a social security account statement pursuant to section 1143(c) of the Social Security Act, for use only by officers, employees or agents of the Social Security Administration for purposes of mailing such statement to such taxpayer.”.*

(2) **SAFEGUARDS.**—*Section 6103(p)(4) of such Code (relating to safeguards) is amended, in the matter following subparagraph (f)(iii), by striking “subsection (m)(2), (4), or (6)” and inserting “paragraph (2), (4), (6), or (7) of subsection (m)”.*

(3) **UNAUTHORIZED DISCLOSURE PENALTIES.**—*Paragraph (2) of section 7213(a) of such Code (relating to unauthorized disclosure of returns and return information) is amended by striking “(m)(2), (4), or (6)” and inserting “(m)(2), (4), (6), or (7)”.*

SEC. 5112. TRIAL WORK PERIOD DURING ROLLING FIVE-YEAR PERIOD FOR ALL DISABLED BENEFICIARIES.

(a) **IN GENERAL.**—*Section 222(c) (42 U.S.C. 422(c)) is amended—*

- (1) *in paragraph (4)(A), by striking “, beginning on or after the first day of such period,” and inserting “, in any period of 60 consecutive months,”; and*
- (2) *by striking paragraph (5).*

(b) **EFFECTIVE DATE.**—*The amendments made by subsection (a) shall take effect on January 1, 1992.*

SEC. 5113. CONTINUATION OF BENEFITS ON ACCOUNT OF PARTICIPATION IN A NON-STATE VOCATIONAL REHABILITATION PROGRAM.

(a) **IN GENERAL.**—*Section 225(b) (42 U.S.C. 425(b)) is amended—*

- (1) *by striking paragraph (1) and inserting the following new paragraph:*

“(1) *such individual is participating in a program of vocational rehabilitation services approved by the Secretary, and”;*
and

- (2) *in paragraph (2), by striking “Commissioner of Social Security” and inserting “Secretary”.*

(b) *PAYMENTS AND PROCEDURES*.—Section 1631(a)(6) (42 U.S.C. 1383(a)(6)) is amended—

(1) by striking subparagraph (A) and inserting the following new subparagraph:

“(A) such individual is participating in a program of vocational rehabilitation services approved by the Secretary, and”; and

(2) in subparagraph (B), by striking “Commissioner of Social Security” and inserting “Secretary”.

(c) *EFFECTIVE DATE*.—The amendments made by this section shall be effective with respect to benefits payable for months after the eleventh month following the month in which this Act is enacted and shall apply only with respect to individuals whose blindness or disability has or may have ceased after such eleventh month.

SEC. 5114. LIMITATION ON NEW ENTITLEMENT TO SPECIAL AGE-72 PAYMENTS.

(a) *IN GENERAL*.—Section 228(a)(2) (42 U.S.C. 428(a)(2)) is amended by striking “(B)” and inserting “(B)(i) attained such age after 1967 and before 1972, and (ii)”.

(b) *EFFECTIVE DATE*.—The amendment made by subsection (a) shall apply with respect to benefits payable on the basis of applications filed after the date of the enactment of this Act.

SEC. 5115. ELIMINATION OF ADVANCED CREDITING TO THE TRUST FUNDS OF SOCIAL SECURITY PAYROLL TAXES.

(a) *IN GENERAL*.—Section 201(a) (42 U.S.C. 401(a)) is amended—

(1) in the first sentence following clause (4)—

(A) by striking “monthly on the first day of each calendar month” both places it appears and inserting “from time to time”;

(B) by striking “to be paid to or deposited into the Treasury during such month” and inserting “paid to or deposited into the Treasury”; and

(2) in the last sentence, by striking “Fund;” and inserting “Fund. Notwithstanding the preceding sentence, in any case in which the Secretary of the Treasury determines that the assets of either such Trust Fund would otherwise be inadequate to meet such Fund’s obligations for any month, the Secretary of the Treasury shall transfer to such Trust Fund on the first day of such month the amount which would have been transferred to such Fund under this section as in effect on October 1, 1990; and”.

(c) *EFFECTIVE DATE*.—The amendments made by this section shall become effective on the first day of the month following the month in which this Act is enacted.

SEC. 5116. ELIMINATION OF ELIGIBILITY FOR RETROACTIVE BENEFITS FOR CERTAIN INDIVIDUALS ELIGIBLE FOR REDUCED BENEFITS.

(a) *IN GENERAL*.—Section 202(j)(4) (42 U.S.C. 402(j)(4)) is amended—

(1) in subparagraph (A), by striking “if the effect” and all that follows and inserting “if the amount of the monthly benefit to which such individual would otherwise be entitled for any such month would be subject to reduction pursuant to subsection (q).”; and

(2) in subparagraph (B), by striking clauses (i) and (iv) and by redesignating clauses (ii), (iii), and (v) as clauses (i), (ii), and (iii), respectively.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to applications for benefits filed on or after January 1, 1991.

SEC. 5117. CONSOLIDATION OF OLD METHODS OF COMPUTING PRIMARY INSURANCE AMOUNTS.

(a) **CONSOLIDATION OF COMPUTATION METHODS.**—

(1) **IN GENERAL.**—Section 215(a)(5) (42 U.S.C. 415(a)(5)) is amended—

(A) by striking “For purposes of” and inserting “(A) Subject to subparagraphs (B), (C), (D) and (E), for purposes of”;

(B) by striking the last sentence; and

(C) by adding at the end the following new subparagraphs:

“(B)(i) Subject to clauses (ii), (iii), and (iv), and notwithstanding any other provision of law, the primary insurance amount of any individual described in subparagraph (C) shall be, in lieu of the primary insurance amount as computed pursuant to any of the provisions referred to in subparagraph (D), the primary insurance amount computed under subsection (a) of section 215 as in effect in December 1978, without regard to subsection (b)(4) and (c) of such section as so in effect.

“(ii) The computation of a primary insurance amount under this subparagraph shall be subject to section 104(j)(2) of the Social Security Amendments of 1972 (relating to the number of elapsed years under section 215(b)).

“(iii) In computing a primary insurance amount under this subparagraph, the dollar amount specified in paragraph (3) of section 215(a) (as in effect in December 1978) shall be increased to \$11.50.

“(iv) In the case of an individual to whom section 215(d) applies, the primary insurance amount of such individual shall be the greater of—

“(I) the primary insurance amount computed under the preceding clauses of this subparagraph, or

“(II) the primary insurance amount computed under section 215(d).

“(C) An individual is described in this subparagraph if—

“(i) paragraph (1) does not apply to such individual by reason of such individual’s eligibility for an old-age or disability insurance benefit, or the individual’s death, prior to 1979, and

“(ii) such individual’s primary insurance amount computed under this section as in effect immediately before the date of the enactment of the Omnibus Budget Reconciliation Act of 1990 would have been computed under the provisions described in subparagraph (D).

“(D) The provisions described in this subparagraph are—

“(i) the provisions of this subsection as in effect prior to the enactment of the Social Security Amendments of 1965, if such provisions would preclude the use of wages prior to 1951 in the computation of the primary insurance amount,

"(ii) the provisions of section 209 as in effect prior to the enactment of the Social Security Act Amendments of 1950, and

"(iii) the provisions of section 215(d) as in effect prior to the enactment of the Social Security Amendments of 1977.

"(E) For purposes of this paragraph, the table for determining primary insurance amounts and maximum family benefits contained in this section in December 1978 shall be revised as provided by subsection (i) for each year after 1978."

(2) COMPUTATION OF PRIMARY INSURANCE BENEFIT UNDER 1939 ACT.—

(A) DIVISION OF WAGES BY ELAPSED YEARS.—Section 215(d)(1) (42 U.S.C. 415(d)(1)) is amended—

(i) in subparagraph (A), by inserting "and subject to section 104(j)(2) of the Social Security Amendments of 1972" after "thereof"; and

(ii) by striking "(B) For purposes" in subparagraph (B) and all that follows through clause (ii) of such subparagraph and inserting the following:

"(B) For purposes of subparagraphs (B) and (C) of subsection (b)(2) (as so in effect)—

"(i) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual—

"(I) shall, in the case of an individual who attained age 21 prior to 1950, be divided by the number of years (hereinafter in this subparagraph referred to as the 'divisor') elapsing after the year in which the individual attained age 20, or 1936 if later, and prior to the earlier of the year of death or 1951, except that such divisor shall not include any calendar year entirely included in a period of disability, and in no case shall the divisor be less than one, and

"(II) shall, in the case of an individual who died before 1950 and before attaining age 21, be divided by the number of years (hereinafter in this subparagraph referred to as the 'divisor') elapsing after the second year prior to the year of death, or 1936 if later, and prior to the year of death, and in no case shall the divisor be less than one; and

"(ii) the total wages prior to 1951 (as defined in subparagraph (C) of this paragraph) of an individual who either attained age 21 after 1949 or died after 1949 before attaining age 21, shall be divided by the number of years (hereinafter in this subparagraph referred to as the 'divisor') elapsing after 1949 and prior to 1951."

(B) CREDITING OF WAGES TO YEARS.—Clause (iii) of section 215(d)(1)(B) (42 U.S.C. 415(d)(1)(B)(iii)) is amended to read as follows:

"(iii) if the quotient exceeds \$3,000, only \$3,000 shall be deemed to be the individual's wages for each of the years which were used in computing the amount of the divisor, and the remainder of the individual's total wages prior to 1951 (I) if less than \$3,000, shall be deemed credited to the computation base year (as defined in subsection (b)(2) as in effect in December 1977) immediately preceding the earliest

year used in computing the amount of the divisor, or (II) if \$3,000 or more, shall be deemed credited, in \$3,000 increments, to the computation base year (as so defined) immediately preceding the earliest year used in computing the amount of the divisor and to each of the computation base years (as so defined) consecutively preceding that year, with any remainder less than \$3,000 being credited to the computation base year (as so defined) immediately preceding the earliest year to which a full \$3,000 increment was credited; and”.

(C) **APPLICABILITY.**—Section 215(d) is further amended—

(i) in paragraph (2)(B), by striking “except as provided in paragraph (3),”;

(ii) by striking paragraph (2)(C) and inserting the following:

“(C)(i) who becomes entitled to benefits under section 202(a) or 223 or who dies, or

“(ii) whose primary insurance amount is required to be recomputed under paragraph (2), (6), or (7) of subsection (f) or under section 231.”; and

(iii) by striking paragraphs (3) and (4).

(3) **CONFORMING AMENDMENTS.**—

(A) Section 215(i)(4) (42 U.S.C. 415(i)(4)) is amended in the first sentence by inserting “and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990” after “as then in effect”.

(B) Section 203(a)(8) (42 U.S.C. 403(a)(8)) is amended in the first sentence by inserting “and as amended by section 5117 of the Omnibus Budget Reconciliation Act of 1990,” after “December 1978” the second place it appears.

(C) Section 215(c) (42 U.S.C. 415(c)) is amended by striking “This” and inserting “Subject to the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990, this”.

(D) Section 215(f)(7) (42 U.S.C. 415(f)(7)) is amended by striking the period at the end of the first sentence and inserting “, including a primary insurance amount computed under any such subsection whose operation is modified as a result of the amendments made by section 5117 of the Omnibus Budget Reconciliation Act of 1990”.

(E)(i) Section 215(d) (42 U.S.C. 415(d)) is further amended by redesignating paragraph (5) as paragraph (3).

(ii) Subsections (a)(7)(A), (a)(7)(C)(ii), and (f)(9)(A) of section 215 (42 U.S.C. 415) are each amended by striking “subsection (d)(5)” each place it appears and inserting “subsection (d)(3)”.

“(iii) Section 215(f)(9)(B) (42 U.S.C. 415(f)(9)(B)) is amended by striking “subsection (a)(7) or (d)(5)” each place it appears and inserting “subsection (a)(7) or (d)(3)”.

(4) **EFFECTIVE DATE.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), the amendments made by this subsection shall apply with respect to the computation of the primary insurance amount of any insured individual in any case in which a

person becomes entitled to benefits under section 202 or 223 on the basis of such insured individual's wages and self-employment income for months after the 18-month period following the month in which this Act is enacted, except that such amendments shall not apply if any person is entitled to benefits based on the wages and self-employment income of such insured individual for the month preceding the initial month of such person's entitlement to such benefits under section 202 or 223.

(B) **RECOMPUTATIONS.**—The amendments made by this subsection shall apply with respect to any primary insurance amount upon the recomputation of such primary insurance amount if such recomputation is first effective for monthly benefits for months after the 18-month period following the month in which this Act is enacted.

(b) **BENEFITS IN CASE OF VETERANS.**—Section 217(b) (42 U.S.C. 417(b)) is amended—

(1) in the first sentence of paragraph (1), by striking "Any" and inserting "Subject to paragraph (3), any"; and

(2) by adding at the end the following new paragraph:

"(3)(A) The preceding provisions of this subsection shall apply for purposes of determining the entitlement to benefits under section 202, based on the primary insurance amount of the deceased World War II veteran, of any surviving individual only if such surviving individual makes application for such benefits before the end of the 18-month period after the month in which the Omnibus Budget Reconciliation Act of 1990 was enacted.

"(B) Subparagraph (A) shall not apply if any person is entitled to benefits under section 202 based on the primary insurance amount of such veteran for the month preceding the month in which such application is made."

(c) **APPLICABILITY OF ALTERNATIVE METHOD FOR DETERMINING QUARTERS OF COVERAGE WITH RESPECT TO WAGES IN THE PERIOD FROM 1937 TO 1950.**—

(1) **APPLICABILITY WITHOUT REGARD TO NUMBER OF ELAPSED YEARS.**—Section 213(c) (42 U.S.C. 413(c)) is amended—

(A) by inserting "and 215(d)" after "214(a)"; and

(B) by striking "except where—" and all that follows and inserting the following: "except where such individual is not a fully insured individual on the basis of the number of quarters of coverage so derived plus the number of quarters of coverage derived from the wages and self-employment income credited to such individual for periods after 1950."

(2) **APPLICABILITY WITHOUT REGARD TO DATE OF DEATH.**—Section 155(b)(2) of the Social Security Amendments of 1967 is amended by striking "after such date".

(3) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply only with respect to individuals who—

(A) make application for benefits under section 202 of the Social Security Act after the 18-month period following the month in which this Act is enacted, and

(B) are not entitled to benefits under section 227 or 228 of such Act for the month in which such application is made.

SEC. 5118. SUSPENSION OF DEPENDENT'S BENEFITS WHEN THE WORKER IS IN AN EXTENDED PERIOD OF ELIGIBILITY.

(a) **IN GENERAL.**—Section 223(e) (42 U.S.C. 623(e)) is amended by—

(1) by inserting "(1)" after "(e)"; and

(2) by adding at the end the following new paragraph:

"(2) No benefit shall be payable under section 202 on the basis of the wages and self-employment income of an individual entitled to a benefit under subsection (a)(1) of this section for any month for which the benefit of such individual under subsection (a)(1) is not payable under paragraph (1)."

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to benefits for months after the date of the enactment of this Act.

SEC. 5119. ENTITLEMENT TO BENEFITS OF DEEMED SPOUSE AND LEGAL SPOUSE.

(a) **CONTINUED ENTITLEMENT OF DEEMED SPOUSE DESPITE ENTITLEMENT OF LEGAL SPOUSE.**—Section 216(h)(1) (42 U.S.C. 416(h)(1)) is amended—

(1) in subparagraph (A)—

(A) by inserting "(i)" after "(h)(1)(A)"; and

(B) by striking "If such courts" in the second sentence and inserting the following:

"(ii) If such courts"; and

(2) in subparagraph (B)—

(A) by inserting "(i)" after "(B)";

(B) by striking "The provisions of the preceding sentence" in the second sentence and inserting the following:

"(ii) The provisions of clause (i)";

(C) by striking "(i) if another" in the second sentence and all that follows through "or (ii)";

(D) by striking "The entitlement" in the third sentence and inserting the following:

"(iii) The entitlement";

(E) by striking "subsection (b), (c), (e), (f), or (g)" the first place it appears in the third sentence and inserting "subsection (b) or (c)";

(F) by striking "wife, widow, husband, or widower" the first place it appears in the third sentence and inserting "wife or husband";

(G) by striking "(i) in which" in the third sentence and all that follows through "in which such applicant entered" and inserting "in which such person enters";

(H) by striking "For purposes" in the fourth sentence and inserting the following:

"(iv) For purposes";

and

(I) by striking "(i)" and "(ii)" in the fourth sentence and inserting "(I)" and "(II)", respectively.

(b) **TREATMENT OF DIVORCE IN THE CONTEXT OF INVALID MARRIAGE.**—Section 216(h)(1)(B)(i) (as amended by subsection (a)) is further amended—

(1) by striking "where under subsection (b), (c), (f), or (g) such applicant is not the wife, widow, husband, or widower of such individual" and inserting "where under subsection (b), (c), (d),

(f), or (g) such applicant is not the wife, divorced wife, widow, surviving divorced wife, husband, divorced husband, widower, or surviving divorced husband of such individual";

(2) by striking "and such applicant" and all that follows through "files the application,"

(3) by striking "subsections (b), (c), (f), and (g)" and inserting "subsections (b), (c), (d), (f), and (g)"; and

(4) by adding at the end the following new sentences: "Notwithstanding the preceding sentence, in the case of any person who would be deemed under the preceding sentence a wife, widow, husband, or widower of the insured individual, such marriage shall not be deemed to be a valid marriage unless the applicant and the insured individual were living in the same household at the time of the death of the insured individual or (if the insured individual is living) at the time the applicant files the application. A marriage that is deemed to be a valid marriage by reason of the preceding sentence shall continue to be deemed a valid marriage if the insured individual and the person entitled to benefits as the wife or husband of the insured individual are no longer living in the same household at the time of the death of such insured individual."

(c) **TREATMENT OF MULTIPLE ENTITLEMENTS UNDER THE FAMILY MAXIMUM.**—Section 203(a)(3) (42 U.S.C. 403(a)(3)) is amended by adding after subparagraph (C) the following new subparagraph:

"(D) In any case in which—

"(i) two or more individuals are entitled to monthly benefits for the same month as a spouse under subsection (b) or (c) of section 202, or as a surviving spouse under subsection (e), (f), or (g) of section 202,

"(ii) at least one of such individuals is entitled by reason of subparagraph (A)(ii) or (B) of section 216(h)(1), and

"(iii) such entitlements are based on the wages and self-employment income of the same insured individual,

the benefit of the entitled individual whose entitlement is based on a valid marriage (as determined without regard to subparagraphs (A)(ii) and (B) of section 216(h)(1)) to such insured individual shall, for such month and all months thereafter, be determined without regard to this subsection, and the benefits of all other individuals who are entitled, for such month or any month thereafter, to monthly benefits under section 202 based on the wages and self-employment income of such insured individual shall be determined as if such entitled individual were not entitled to benefits for such month."

(d) **CONFORMING AMENDMENT.**—Section 203(a)(6) (42 U.S.C. 403(a)(6)) is amended by inserting "(3)(D)," after "(3)(C),".

(e) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—The amendments made by this section shall apply with respect to benefits for months after December 1990.

(2) **APPLICATION REQUIREMENT.**—

(A) **GENERAL RULE.**—Except as provided in subparagraph (B), the amendments made by this section shall apply only with respect to benefits for which application is filed with the Secretary of Health and Human Services after December 31, 1990.

(B) *EXCEPTION FROM APPLICATION REQUIREMENT.*—Subparagraph (A) shall not apply with respect to the benefits of any individual if such individual is entitled to a benefit under subsection (b), (c), (e), or (f) of section 202 of the Social Security Act for December 1990 and the individual on whose wages and self-employment income such benefit for December 1990 is based is the same individual on the basis of whose wages and self-employment income application would otherwise be required under subparagraph (A).

SEC. 5120. VOCATIONAL REHABILITATION DEMONSTRATION PROJECTS.

(a) *DEMONSTRATION PROJECT.*—

(1) *IN GENERAL.*—Pursuant to section 505 of the Social Security Disability Amendments of 1980, the Secretary of Health and Human Services shall develop and carry out under this section demonstration projects in each of not fewer than three States. Each such demonstration project shall be designed to assess the advantages and disadvantages of permitting disabled beneficiaries (as defined in paragraph (3)) to select, from among both public and private qualified vocational rehabilitation providers, providers of vocational rehabilitation services directed at enabling such beneficiaries to engage in substantial gainful activity. Each such demonstration project shall commence as soon as practicable after the date of the enactment of this Act and shall remain in operation until the end of fiscal year 1993.

(2) *SCOPE AND PARTICIPATION.*—Each demonstration project shall be of sufficient scope and open to sufficient participation by disabled beneficiaries so as to permit meaningful determinations under subsection (b).

(3) *DISABLED BENEFICIARY.*—For purposes of this section, the term “disabled beneficiary” means an individual who is entitled to disability insurance benefits under section 223 of the Social Security Act or benefits under section 202 of such Act based on such individual's own disability.

(b) *MATTERS TO BE DETERMINED.*—In the course of each demonstration project conducted under this section, the Secretary shall determine the following:

(1) the extent to which disabled beneficiaries participate in the process of selecting providers of rehabilitation services, and their reasons for participating or not participating;

(2) notable characteristics of participating disabled beneficiaries (including their impairments), classified by the type of provider selected;

(3) the various needs for rehabilitation demonstrated by participating disabled beneficiaries, classified by the type of provider selected;

(4) the extent to which providers of rehabilitation services which are not agencies or instrumentalities of States accept referrals of disabled beneficiaries under procedures in effect under section 222(d) of the Social Security Act as of the date of the enactment of this Act relating to reimbursement for such services and the most effective way of reimbursing such providers in accordance with such provisions;

(5) the extent to which providers participating in the demonstration projects enter into contracts with third parties for services and the types of such services;

(6) whether, and if so the extent to which, disabled beneficiaries who select their own providers of rehabilitation services are more likely to engage in substantial gainful activity and thereby terminate their entitlement under section 202 or 223 of the Social Security Act than those who do not;

(7) the cost effectiveness of permitting disabled beneficiaries to select their providers of vocational rehabilitation services, and the comparative cost effectiveness of different types of providers; and

(8) the feasibility of establishing a permanent national program for allowing disabled beneficiaries to choose their own qualified vocational rehabilitation provider and any additional safeguards which would be necessary to assure the effectiveness of such a program.

(c) **PROCEDURAL REQUIREMENTS.—**

(1) **SELECTION OF PARTICIPANTS.—**The Secretary shall select for participation in each demonstration project under this section disabled beneficiaries for whom there is a reasonable likelihood that rehabilitation services provided to them will result in performance by them of substantial gainful activity for a continuous period of nine months prior to termination of the project.

(2) **SELECTION OF PROVIDERS OF REHABILITATION SERVICES.—**The Secretary shall select qualified rehabilitation agencies to serve as providers of rehabilitation services in the geographic area covered by each demonstration project conducted under this section. The Secretary shall make such selection after consultation with disabled individuals and organizations representing such individuals. With respect to each demonstration project, the Secretary may approve on a case-by-case basis additional qualified rehabilitation agencies from outside the geographic area covered by the project to serve particular disabled beneficiaries.

(3) **REIMBURSEMENT OF PROVIDERS.—**

(A) Except as provided in subparagraph (B), providers of rehabilitation services under each demonstration project under this section shall be reimbursed in accordance with the procedures in effect under the provisions of section 222(d) of the Social Security Act as of the date of the enactment of this Act relating to reimbursement for services provided under such section.

(B) The Secretary may contract with providers of rehabilitation services under each demonstration project under this section on a fee-for-service basis in order to—

(i) conduct vocational evaluations directed at identifying those disabled beneficiaries who have reasonable potential for engaging in substantial gainful activity and thereby terminating their entitlement to benefits under section 202 or 223 of the Social Security Act if provided with vocational rehabilitation services as participants in the project, and

(ii) develop jointly with each disabled beneficiary so identified an individualized, written rehabilitation program.

(C) Each written rehabilitation program developed pursuant to subparagraph (B)(ii) for any participant shall include among its provisions—

(i) a statement of the participant's rehabilitation goal,

(ii) a statement of the specific rehabilitation services to be provided and of the identity of the provider to furnish such services,

(iii) the projected date for the initiation of such services and their anticipated duration, and

(iv) objective criteria and an evaluation procedure and schedule for determining whether the stated rehabilitation goal is being achieved.

(d) **REPORTS.**—The Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an interim written report on the progress of the demonstration projects conducted under this section not later than April 1, 1992, together with any related data and materials which the Secretary considers appropriate. The Secretary shall submit a final written report to such Committees addressing the matters to be determined under subsection (b) not later than April 1, 1994.

(e) **STATE.**—For purposes of this section, the term "State" means a State, including the entities included in such term by section 210(h) of the Social Security Act (42 U.S.C. 410(h)).

(f) **CONTINUATION OF DEMONSTRATION AUTHORITY.**—Section 505(c) of the Social Security Disability Amendments of 1980 (42 U.S.C. 1310 note) is amended to read as follows:

"(c) The Secretary shall submit to the Congress a final report with respect to all experiments and demonstration projects carried out under this section (other than demonstration projects conducted under section 5120 of the Omnibus Budget Reconciliation of 1990) no later than October 1, 1993."

SEC. 5121. EXEMPTION FOR CERTAIN ALIENS, RECEIVING AMNESTY UNDER THE IMMIGRATION AND NATIONALITY ACT, FROM PROSECUTION FOR MISREPORTING OF EARNINGS OR MISUSE OF SOCIAL SECURITY ACCOUNT NUMBERS OR SOCIAL SECURITY CARDS.

(a) **IN GENERAL.**—Section 208 (42 U.S.C. 408) is amended by adding at the end the following:

"(d)(1) Except as provided in paragraph (2), an alien—

"(A) whose status is adjusted to that of lawful temporary resident under section 210 or 245A of the Immigration and Nationality Act or under section 902 of the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989,

"(B) whose status is adjusted to that of permanent resident—

"(i) under section 202 of the Immigration Reform and Control Act of 1986, or

"(ii) pursuant to section 249 of the Immigration and Nationality Act, or

"(C) who is granted special immigrant status under section 101(a)(27)(I) of the Immigration and Nationality Act,

shall not be subject to prosecution for any alleged conduct described in paragraph (6) or (7) of subsection (a) if such conduct is alleged to have occurred prior to 60 days after the date of the enactment of the Omnibus Budget Reconciliation Act of 1990.

"(2) Paragraph (1) shall not apply with respect to conduct (described in subsection (a)(7)(C)) consisting of—

"(A) selling a card that is, or purports to be, a social security card issued by the Secretary,

"(B) possessing a social security card with intent to sell it, or

"(C) counterfeiting a social security card with intent to sell it.

"(3) Paragraph (1) shall not apply with respect to any criminal conduct involving both the conduct described in subsection (a)(7) to which paragraph (1) applies and any other criminal conduct if such other conduct would be criminal conduct if the conduct described in subsection (a)(7) were not committed."

(b) **TECHNICAL AND CONFORMING AMENDMENTS.**—So much of section 208 as precedes subsection (d) (as added by subsection (a) of this section) is amended—

(1) in subsection (a), by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively; (2) in subsection (g), by redesignating paragraphs (1), (2), and (3) as subparagraphs (A), (B), and (C), respectively; (3) by redesignating subsections (a) through (h) as paragraphs (1) through (8), respectively; (4) by inserting "(a)" before "Whoever"; (5) by inserting "(b)" at the beginning of the next-to-last undesignated paragraph; and (6) by inserting "(c)" at the beginning of the last undesignated paragraph.

SEC. 5122. REDUCTION OF AMOUNT OF WAGES NEEDED TO EARN A YEAR OF COVERAGE APPLICABLE IN DETERMINING SPECIAL MINIMUM PRIMARY INSURANCE AMOUNT.

(a) **IN GENERAL.**—Section 215(a)(1)(C)(ii) (42 U.S.C. 415(a)(1)(C)(ii)) is amended by striking "of not less than 25 percent" the first place it appears and all that follows through "1977) if" and inserting "of not less than 25 percent (in the case of a year after 1950 and before 1978) of the maximum amount which (pursuant to subsection (e)) may be counted for such year, or 25 percent (in the case of a year after 1977 and before 1991) or 15 percent (in the case of a year after 1990) of the maximum amount which (pursuant to subsection (e)) could be counted for such year if".

(b) **RETENTION OF CURRENT AMOUNT OF WAGES NEEDED TO EARN A YEAR OF COVERAGE FOR PURPOSES OF WINDFALL ELIMINATION PROVISION.**—Section 215(a)(7)(D) (42 U.S.C. 415(a)(7)(D)) is amended—

(1) in the first sentence, by striking "(as defined in paragraph (1)(C)(ii))"; and

(2) by adding at the end (after the table) the following new flush sentence:

"For purposes of this subparagraph, the term 'year of coverage' shall have the meaning provided in paragraph (1)(C)(ii), except that the reference to '15 percent' therein shall be deemed to be a reference to '25 percent'."

SEC. 5123. CHARGING OF EARNINGS OF CORPORATE DIRECTORS.

(a) **IN GENERAL.**—

(1) Title II is amended by moving the last undesignated paragraph of section 211(a) of such title (as added by section 9022(a) of the Omnibus Budget Reconciliation Act of 1987) to the end of section 203(f)(5) of such title.

(2) The undesignated paragraph moved to section 203(f)(5) of the Social Security Act by paragraph (1) is amended—

(A) by striking “Any income of an individual which results from or is attributable to” and inserting “(E) For purposes of this section, any individual’s net earnings from self-employment which result from or are attributable to”;

(B) by striking “the income is actually paid” and inserting “the income, on which the computation of such net earnings from self-employment is based, is actually paid”;

and
(C) by striking “unless it was” and inserting “unless such income was”.

(3) The last undesignated paragraph of section 1402(a) of the Internal Revenue Code of 1986 (as added by section 9022(b) of the Omnibus Budget Reconciliation Act of 1987) is repealed.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to income received for services performed in taxable years beginning after December 31, 1990.

SEC. 5124. COLLECTION OF EMPLOYEE SOCIAL SECURITY AND RAILROAD RETIREMENT TAXES ON TAXABLE GROUP-TERM LIFE INSURANCE PROVIDED TO RETIREES.

(a) **SOCIAL SECURITY TAXES.**—Section 3102 of the Internal Revenue Code of 1986 (relating to deduction of tax from wages) is amended by adding at the end thereof the following new subsection:

“(d) **SPECIAL RULE FOR CERTAIN TAXABLE GROUP-TERM LIFE INSURANCE BENEFITS.**—

“(1) **IN GENERAL.**—In the case of any payment for group-term life insurance to which this subsection applies—

“(A) subsection (a) shall not apply,

“(B) the employer shall separately include on the statement required under section 6051—

“(i) the portion of the wages which consists of payments for group-term life insurance to which this subsection applies, and

“(ii) the amount of the tax imposed by section 3101 on such payments, and

“(C) the tax imposed by section 3101 on such payments shall be paid by the employee.

“(2) **BENEFITS TO WHICH SUBSECTION APPLIES.**—This subsection shall apply to any payment for group-term life insurance to the extent—

“(A) such payment constitutes wages, and

“(B) such payment is for coverage for periods during which an employment relationship no longer exists between the employee and the employer.”

(b) **RAILROAD RETIREMENT TAXES.**—Section 3202 of such Code (relating to deduction of tax from compensation) is amended by adding at the end thereof the following new subsection:

“(d) **SPECIAL RULE FOR CERTAIN TAXABLE GROUP-TERM LIFE INSURANCE BENEFITS.**—

"(1) *IN GENERAL.*—In the case of any payment for group-term life insurance to which this subsection applies—

"(A) subsection (a) shall not apply,

"(B) the employer shall separately include on the statement required under section 6051—

"(i) the portion of the compensation which consists of payments for group-term life insurance to which this subsection applies, and

"(ii) the amount of the tax imposed by section 3201 on such payments, and

"(C) the tax imposed by section 3201 on such payments shall be paid by the employee.

"(2) *BENEFITS TO WHICH SUBSECTION APPLIES.*—This subsection shall apply to any payment for group-term life insurance to the extent—

"(A) such payment constitutes compensation, and

"(B) such payment is for coverage for periods during which an employment relationship no longer exists between the employee and the employer."

(c) *EFFECTIVE DATE.*—The amendments made by this section shall apply to coverage provided after December 31, 1990.

SEC. 5125. TIER 1 RAILROAD RETIREMENT TAX RATES EXPLICITLY DETERMINED BY REFERENCE TO SOCIAL SECURITY TAXES.

(a) *TAX ON EMPLOYEES.*—Subsection (a) of section 3201 of the Internal Revenue Code of 1986 (relating to rate of tax) is amended—

(1) by striking "following" and inserting "applicable", and

(2) by striking "employee:" and all that follows and inserting "employee. For purposes of the preceding sentence, the term 'applicable percentage' means the percentage equal to the sum of the rates of tax in effect under subsections (a) and (b) of section 3101 for the calendar year."

(b) *TAX ON EMPLOYEE REPRESENTATIVES.*—Paragraph (1) of section 3211(a) of such Code (relating to rate of tax) is amended—

(1) by striking "following" and inserting "applicable", and

(2) by striking "representative:" and all that follows and inserting "representative. For purposes of the preceding sentence, the term 'applicable percentage' means the percentage equal to the sum of the rates of tax in effect under subsections (a) and (b) of section 3101 and subsections (a) and (b) of section 3111 for the calendar year."

(c) *TAX ON EMPLOYERS.*—Subsection (a) of section 3221 of such Code (relating to rate of tax) is amended—

(1) by striking "following" and inserting "applicable", and

(2) by striking "employer:" and all that follows and inserting "employer. For purposes of the preceding sentence, the term 'applicable percentage' means the percentage equal to the sum of the rates of tax in effect under subsections (a) and (b) of section 3111 for the calendar year."

SEC. 5126. TRANSFER TO RAILROAD RETIREMENT ACCOUNT.

Subsection (c)(1)(A) of section 224 of the Railroad Retirement Solvency Act of 1983 (relating to section 72(r) revenue increase transferred to certain railroad accounts) is amended by striking "1990" and inserting "1992".

SEC. 5127. WAIVER OF 2-YEAR WAITING PERIOD FOR INDEPENDENT ENTITLEMENT TO DIVORCED SPOUSE'S BENEFITS.

(a) **WAIVER FOR PURPOSES OF DEDUCTIONS ON ACCOUNT OF WORK.**—Section 203(b)(2) (42 U.S.C. 403(b)(2)) is amended—

(1) by striking “(2) When” and all that follows through “2 years, the benefit” and inserting the following:

“(2)(A) Except as provided in subparagraph (B), in any case in which—

“(i) any of the other persons referred to in paragraph (1)(B) is entitled to monthly benefits as a divorced spouse under section 202(b) or (c) for any month, and

“(ii) such person has been divorced for not less than 2 years, the benefit”; and

(2) by adding at the end the following new subparagraph:

“(B) Clause (ii) of subparagraph (A) shall not apply with respect to any divorced spouse in any case in which the individual referred to in paragraph (1) became entitled to old-age insurance benefits under section 202(a) before the date of the divorce.”.

(b) **WAIVER IN CASE OF NONCOVERED WORK OUTSIDE THE UNITED STATES.**—Section 203(d)(1)(B) (42 U.S.C. 403(d)(1)(B)) is amended—

(1) by striking “(B) When” and all that follows through “2 years, the benefit” and inserting the following:

“(B)(i) Except as provided in clause (ii), in any case in which—

“(I) a divorced spouse is entitled to monthly benefits under section 202(b) or (c) for any month, and

“(II) such divorced spouse has been divorced for not less than 2 years, the benefit”; and

(2) by adding at the end the following new clause:

“(ii) Subclause (II) of clause (i) shall not apply with respect to any divorced spouse in any case in which the individual entitled to old-age insurance benefits referred to in subparagraph (A) became entitled to such benefits before the date of the divorce.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to benefits for months after December 1990.

SEC. 5128. MODIFICATION OF THE PREEFFECTUATION REVIEW REQUIREMENT APPLICABLE TO DISABILITY INSURANCE CASES.

(a) **IN GENERAL.**—Section 221(c)(3) (42 U.S.C. 421(c)(3)) is amended to read as follows:

“(3)(A) In carrying out the provisions of paragraph (2) with respect to the review of determinations made by State agencies pursuant to this section that individuals are under disabilities (as defined in section 216(i) or 223(d)), the Secretary shall review—

“(i) at least 50 percent of all such determinations made by State agencies on applications for benefits under this title, and

“(ii) other determinations made by State agencies pursuant to this section to the extent necessary to assure a high level of accuracy in such other determinations.

“(B) In conducting reviews pursuant to subparagraph (A), the Secretary shall, to the extent feasible, select for review those determinations which the Secretary identifies as being the most likely to be incorrect.

“(C) Not later than April 1, 1992, and annually thereafter, the Secretary shall submit to the Committee on Ways and Means of the

House of Representatives and the Committee on Finance of the Senate a written report setting forth the number of reviews conducted under subparagraph (A)(ii) during the preceding fiscal year and the findings of the Secretary based on such reviews of the accuracy of the determinations made by State agencies pursuant to this section."

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to determinations made by State agencies in fiscal years after fiscal year 1990.

SEC. 5129. RECOVERY OF OASDI OVERPAYMENTS BY MEANS OF REDUCTION IN TAX REFUNDS.

(a) **ADDITIONAL METHOD OF RECOVERY.**—Section 204(a)(1)(A) (42 U.S.C. 404(a)(1)(A)) is amended by inserting after "payments to such overpaid person," the following: "or shall obtain recovery by means of reduction in tax refunds based on notice to the Secretary of the Treasury as permitted under section 3720A of title 31, United States Code,".

(b) **RECOVERY BY MEANS OF REDUCTION IN TAX REFUNDS.**—Section 3720A of title 31, United States Code (relating to collection of debts owed to Federal agencies) is amended—

(1) in subsection (a), by striking "OASDI overpayment and";

(2) by redesignating subsection (f) as subsection (g); and

(3) by inserting the following new subsection after subsection

(e):

"(f)(1) Subsection (a) shall apply with respect to an OASDI overpayment made to any individual only if such individual is not currently entitled to monthly insurance benefits under title II of the Social Security Act.

"(2)(A) The requirements of subsection (b) shall not be treated as met in the case of the recovery of an OASDI overpayment from any individual under this section unless the notification under subsection (b)(1) describes the conditions under which the Secretary of Health and Human Services is required to waive recovery of an overpayment, as provided under section 204(b) of the Social Security Act.

"(B) In any case in which an individual files for a waiver under section 204(b) of the Social Security Act within the 60-day period referred to in subsection (b)(2), the Secretary of Health and Human Services shall not certify to the Secretary of the Treasury that the debt is valid under subsection (b)(4) before rendering a decision on the waiver request under such section 204(b). In lieu of payment, pursuant to subsection (c), to the Secretary of Health and Human Services of the amount of any reduction under this subsection based on an OASDI overpayment, the Secretary of the Treasury shall deposit such amount in the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, whichever is certified to the Secretary of the Treasury as appropriate by the Secretary of Health and Human Services."

(c) **INTERNAL REVENUE CODE PROVISIONS.**—

(1) **IN GENERAL.**—Subsection (d) of section 6402 of the Internal Revenue Code of 1986 (relating to collection of debts owed to Federal agencies) is amended—

(A) in paragraph (1), by striking "any OASDI overpayment and"; and

(B) by striking paragraph (3) and inserting the following new paragraph:

"(3) TREATMENT OF OASDI OVERPAYMENTS.—

"(A) REQUIREMENTS.—Paragraph (1) shall apply with respect to an OASDI overpayment only if the requirements of paragraphs (1) and (2) of section 3720A(f) of title 31, United States Code, are met with respect to such overpayment.

"(B) NOTICE; PROTECTION OF OTHER PERSONS FILING JOINT RETURN.—

"(i) NOTICE.—In the case of a debt consisting of an OASDI overpayment, if the Secretary determines upon receipt of the notice referred to in paragraph (1) that the refund from which the reduction described in paragraph (1)(A) would be made is based upon a joint return, the Secretary shall—

"(I) notify each taxpayer filing such joint return that the reduction is being made from a refund based upon such return, and

"(II) include in such notification a description of the procedures to be followed, in the case of a joint return, to protect the share of the refund which may be payable to another person.

"(ii) ADJUSTMENTS BASED ON PROTECTIONS GIVEN TO OTHER TAXPAYERS ON JOINT RETURN.—If the other person filing a joint return with the person owing the OASDI overpayment takes appropriate action to secure his or her proper share of the refund subject to reduction under this subsection, the Secretary shall pay such share to such other person. The Secretary shall deduct the amount of such payment from amounts which are derived from subsequent reductions in refunds under this subsection and are payable to a trust fund referred to in subparagraph (C).

"(C) DEPOSIT OF AMOUNT OF REDUCTION INTO APPROPRIATE TRUST FUND.—In lieu of payment, pursuant to paragraph (1)(B), of the amount of any reduction under this subsection to the Secretary of Health and Human Services, the Secretary shall deposit such amount in the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, whichever is certified to the Secretary as appropriate by the Secretary of Health and Human Services.

"(D) OASDI OVERPAYMENT.—For purposes of this paragraph, the term 'OASDI overpayment' means any overpayment of benefits made to an individual under title II of the Social Security Act."

(2) PRESERVATION OF REMEDIES.—Subsection (e) of section 6402 of such Code (relating to review of reductions) is amended in the last sentence by inserting before the period the following: "or any such action against the Secretary of Health and Human Services which is otherwise available with respect to re-

coveries of overpayments of benefits under section 204 of the Social Security Act".

(d) **EFFECTIVE DATE.**—The amendments made by this section—

(1) shall take effect January 1, 1991, and

(2) shall not apply to refunds to which the amendments made by section 2653 of the Deficit Reduction Act of 1984 (98 Stat. 1153) do not apply.

SEC. 5130. MISCELLANEOUS TECHNICAL CORRECTIONS.

(a) **IN GENERAL.**—

(1) **AMENDMENT RELATING TO SECTION 7088 OF PUBLIC LAW 100-690.**—Section 208 (42 U.S.C. 408) is amended, in the last undesignated paragraph, by striking "section 405(c)(2) of this title" and inserting "section 205(c)(2)".

(2) **AMENDMENTS RELATING TO SECTION 322 OF PUBLIC LAW 98-21.**—Paragraphs (1) and (2) of section 322(b) of the Social Security Amendments of 1983 (Public Law 98-21, 97 Stat. 121) are each amended by inserting "the first place it appears" before "the following".

(3) **AMENDMENT RELATING TO SECTION 1011B(b)(4) OF PUBLIC LAW 100-647.**—Section 211(a) (42 U.S.C. 411(a)) is amended by redesignating the second paragraph (14) as paragraph (15).

(4) **AMENDMENT RELATING TO SECTION 2003(d) OF PUBLIC LAW 100-647.**—Paragraph (3) of section 3509(d) of the Internal Revenue Code of 1986 (as amended by section 2003(d) of the Technical and Miscellaneous Revenue Act of 1988 (Public Law 100-647; 102 Stat. 3598)) is further amended by striking "subsection (d)(4)" and inserting "subsection (d)(3)".

(5) **AMENDMENT RELATING TO SECTION 10208 OF PUBLIC LAW 101-239.**—Section 209(a)(7)(B) (42 U.S.C. 409(a)(7)(B)) is amended by striking "subparagraph (B)" in the matter following clause (ii) and inserting "clause (ii)".

(b) **EFFECTIVE DATES.**—The amendments made by subsection (a) shall be effective as if included in the enactment of the provision to which it relates.

TITLE VI—ENERGY AND ENVIRONMENTAL PROGRAMS

Subtitle A—Abandoned Mine Reclamation

SEC. 6001. SHORT TITLE.

This subtitle may be cited as the "Abandoned Mine Reclamation Act of 1990".

SEC. 6002. ABANDONED MINE RECLAMATION FUND.

(a) **SOURCES OF DEPOSITS.**—Section 401(b) of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1231(b)) is amended as follows:

(1) Amend paragraph (1) to read as follows:

"(1) the reclamation fees levied under section 402;"

(2) Strike "and" at the end of paragraph (3); strike the period at the end of paragraph (4) and insert "; and"; and add the following new paragraph at the end:

"(iii) does not make the deposit (described in paragraph (1)) required in order to receive credit for the period of service with respect to which the refund relates.

"(B) Notwithstanding the second sentence of paragraph (1), the annuity to which an employee or Member under this paragraph is entitled shall (subject to adjustment under section 8340) be equal to an amount which, when taken together with the unpaid amount referred to in subparagraph (A)(iii), would result in the present value of the total being actuarially equivalent to the present value of the annuity which would otherwise be provided the employee or Member under this subchapter, as computed under subsections (a)-(i) and (n) of section 8339 (treating, for purposes of so computing the annuity which would otherwise be provided under this subchapter, the deposit referred to in subparagraph (A)(iii) as if it had been timely made).

"(C) The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this paragraph."

(2)(A) Section 8334 of title 5, United States Code, is amended in paragraphs (1) and (2) of subsection (e), and in subsection (h), by striking "(d)," and inserting "(d)(1)."

(B) Section 8334(f) and section 8339(i)(1) of title 5, United States Code, are amended by striking "(d)" and inserting "(d)(1)".

(C) Section 8339(e) of title 5, United States Code, is amended by striking "8334(d)" and inserting "8334(d)(1)".

(D) The second sentence of section 8342(a) of title 5, United States Code, is amended by inserting "or 8334(d)(2)" after "8343a".

(3) The amendments made by this subsection shall be effective with respect to any annuity having a commencement date later than December 1, 1990.

SEC. 7002. REFORMS IN THE HEALTH BENEFITS PROGRAM.

(a) **HOSPITALIZATION-COST-CONTAINMENT MEASURES.**—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

"(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

"(1) to implement hospitalization-cost-containment measures, such as measures—

"(A) for verifying the medical necessity of any proposed treatment or surgery;

"(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

"(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

"(D) involving case management, if the circumstances so warrant; and

"(2) to establish incentives to encourage compliance with measures under paragraph (1)."

(b) **IMPROVED CASH MANAGEMENT.**—Section 8909(a) of title 5, United States Code, is amended by adding at the end (as a flush left sentence) the following:

"Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).".

(c) **EXEMPTION FROM STATE PREMIUM TAXES.**—Section 8909 of title 5, United States Code, is amended by adding at the end the following:

"(f)(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

"(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan administration subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity."

(d) **IMPROVED COORDINATION WITH MEDICARE.**—Section 8910 of title 5, United States Code, is amended by adding at the end the following:

"(d) The Office, in consultation with the Department of Health and Human Services, shall develop and implement a system through which the carrier for an approved health benefits plan described by section 8903 or 8903a will be able to identify those annuitants or other individuals covered by such plan who are entitled to benefits under part A or B of title XVIII of the Social Security Act in order to ensure that payments under coordination of benefits with Medicare do not exceed the statutory maximums which physicians may charge Medicare enrollees."

(e) **AMENDMENTS TO PUBLIC LAW 101-76.**—Public Law 101-76 (103 Stat. 556) is amended—

(1) in subsection (a)(1), by striking "contract year 1990 or 1991," and inserting "each of contract years 1990 through 1993 (inclusive)," and

(2) in subsection (c), by striking "contract year 1991," and inserting "a contract year (or any period thereafter),".

(f) **APPLICATION OF CERTAIN MEDICARE LIMITS TO FEDERAL EMPLOYEE HEALTH BENEFITS ENROLLEES AGE 65 OR OLDER.**—(1) Section 8904 of title 5, United States Code, is amended by inserting "(a)" before the first sentence and by adding at the end of the section the following new subsection:

"(b)(1) A plan, other than a prepayment plan described in section 8903(4) of this title, may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not covered to receive Medicare hospital and insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), to pay a charge imposed by any health care provider, for inpatient hospital services which are covered for purposes of benefit payments under

this chapter and part A of title XVIII of the Social Security Act, to the extent that such charge exceeds applicable limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Hospital providers who have in force participation agreements with the Secretary of Health and Human Services consistent with sections 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), whereby the participating provider accepts Medicare benefits as full payment for covered items and services after applicable patient copayments under section 1813 of such Act (42 U.S.C. 1395e) have been satisfied, shall accept equivalent benefit payments and enrollee copayments under this chapter as full payment for services described in the preceding sentence. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a hospital is found to knowingly and willfully violate this subsection on a repeated basis and the Secretary may invoke appropriate sanctions in accordance with section 1866(b)(2) of the Social Security Act (42 U.S.C. 1395cc(b)(2)) and applicable regulations.

"(2) Notwithstanding any other provision of law, the Secretary of Health and Human Services and the Director of the Office of Personnel Management, and their agents, shall exchange any information necessary to implement this subsection.

"(3)(A) Not later than December 1, 1991, and periodically thereafter, the Secretary of Health and Human Services (in consultation with the Director of the Office of Personnel Management) shall supply to carriers of plans described in paragraphs (1) through (3) of section 8903 the Medicare program information necessary for them to comply with paragraph (1).

"(B) For purposes of this paragraph, the term 'Medicare program information' includes the limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww) and the identity of hospitals which have in force agreements with the Secretary of Health and Human Services consistent with section 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc)."

(2) The amendments made by this subsection shall apply with respect to contract years beginning on or after January 1, 1992.

(g) **EFFECTIVE DATE.**—Except as provided in subsection (f), the amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1991.

Subtitle B—Postal Service

SEC. 7101. FUNDING OF COLAS FOR POSTAL SERVICE ANNUITANTS AND SURVIVOR ANNUITANTS.

(a) **EXPANDED SCOPE OF COVERAGE; CHANGE IN PRORATION RULE.**—Section 8348(m)(1) of title 5, United States Code, is amended by striking "October 1, 1986," each place it appears and inserting "July 1, 1971,".

(b) **REPEAL OF PROVISION RELATING TO CERTAIN EARLIER COLAS.**—Section 4002(b) of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239; 103 Stat. 2134) is repealed.

SEC. 8042. PLOT ALLOWANCE ELIGIBILITY.

(a) *In General.*—Section 903(b)(2) of title 38, United States Code, is amended by inserting “(other than a veteran whose eligibility for benefits under this subsection is based on being a veteran of any war)” after “(2) if such veteran”.

(b) *Effective Date.*—This section shall apply to deaths occurring on or after November 1, 1990.

Subtitle F—Miscellaneous

SEC. 8051. USE OF INTERNAL REVENUE SERVICE AND SOCIAL SECURITY ADMINISTRATION DATA FOR INCOME VERIFICATION.

(a) *DISCLOSURE OF TAX INFORMATION.*—(1) Subparagraph (D) of section 6103(l)(7) of the Internal Revenue Code of 1986 (relating to disclosure of return information to Federal, State, and local agencies administering certain programs) is amended—

(A) by striking out “and” at the end of clause (vi);

(B) by striking out the period at the end of clause (vii) and inserting in lieu thereof “; and”; and

(C) by adding at the end the following:

“(viii)(I) any needs-based pension provided under chapter 15 of title 38, United States Code, or under any other law administered by the Secretary of Veterans Affairs;

“(II) parents’ dependency and indemnity compensation provided under section 415 of title 38, United States Code;

“(III) health-care services furnished under section 610(a)(1)(I), 610(a)(2), 610(b), and 612(a)(2)(B) of such title; and

“(IV) compensation paid under chapter 11 of title 38, United States Code, at the 100 percent rate based solely on unemployability and without regard to the fact that the disability or disabilities are not rated as 100 percent disabling under the rating schedule.

Only return information from returns with respect to net earnings from self-employment and wages may be disclosed under this paragraph for use with respect to any program described in clause (viii)(IV). Clause (viii) shall not apply after September 30, 1992.”

(2) The heading of paragraph (7) of section 6103(l) of such Code is amended by striking out “OR THE FOOD STAMP ACT OF 1977” and inserting in lieu thereof “, THE FOOD STAMP ACT OF 1977, OR TITLE 38, UNITED STATES CODE”.

(b) *USE OF INCOME INFORMATION FOR NEEDS-BASED PROGRAMS.*—(1) Chapter 53 of title 38, United States Code, is amended by adding at the end the following new section:

“§ 3117. Use of income information from other agencies: notice and verification

“(a) The Secretary shall notify each applicant for a benefit or service described in subsection (c) of this section that income information furnished by the applicant to the Secretary may be compared with information obtained by the Secretary from the Secretary of Health and Human Services or the Secretary of the Treasury under

section 6103(1)(7)(D)(viii) of the Internal Revenue Code of 1986. The Secretary shall periodically transmit to recipients of such benefits and services additional notifications of such matters.

"(b) The Secretary may not, by reason of information obtained from the Secretary of Health and Human Services or the Secretary of the Treasury under section 6103(1)(7)(D)(viii) of the Internal Revenue Code of 1986, terminate, deny, suspend, or reduce any benefit or service described in subsection (c) of this section until the Secretary takes appropriate steps to verify independently information relating to the following:

"(1) The amount of the asset or income involved.

"(2) Whether such individual actually has (or had) access to such asset or income for the individual's own use.

"(3) The period or periods when the individual actually had such asset or income.

"(c) The benefits and services described in this subsection are the following:

"(1) Needs-based pension benefits provided under chapter 15 of this title or under any other law administered by the Secretary.

"(2) Parents' dependency and indemnity compensation provided under section 415 of this title.

"(3) Health-care services furnished under sections 610(a)(1)(I), 610(a)(2), 610(b), and 612(a)(2)(B) of this title.

"(4) Compensation paid under chapter 11 of this title at the 100 percent rate based solely on unemployability and without regard to the fact that the disability or disabilities are not rated as 100 percent disabling under the rating schedule.

"(d) In the case of compensation described in subsection (c)(4) of this section, the Secretary may independently verify or otherwise act upon wage or self-employment information referred to in subsection (b) of this section only if the Secretary finds that the amount and duration of the earnings reported in that information clearly indicate that the individual may no longer be qualified for a rating of total disability.

"(e) The Secretary shall inform the individual of the findings made by the Secretary on the basis of verified information under subsection (b) of this section, and shall give the individual an opportunity to contest such findings, in the same manner as applies to other information and findings relating to eligibility for the benefit or service involved.

"(f) The Secretary shall pay the expenses of carrying out this section from amounts available to the Department for the payment of compensation and pension.

"(g) The authority of the Secretary to obtain information from the Secretary of the Treasury or the Secretary of Health and Human Services under section 6103(1)(7)(D)(viii) of the Internal Revenue Code of 1986 expires on September 30, 1992."

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

"3117. Use of income information from other agencies: notice and verification."

(c) NOTICE TO CURRENT BENEFICIARIES.—(1) The Secretary of Veterans Affairs shall notify individuals who (as of the date of the en-

actment of this Act) are applicants for or recipients of the benefits described in subsection (c) (other than paragraph (3)) of section 3117 of title 38, United States Code (as added by subsection (b)), that income information furnished to the Secretary by such applicants and recipients may be compared with information obtained by the Secretary from the Secretary of Health and Human Services or the Secretary of the Treasury under clause (viii) of section 6103(1)(7)(D) of the Internal Revenue Code of 1986 (as added by subsection (a)).

(2) Notification under paragraph (1) shall be made not later than 90 days after the date of the enactment of this Act.

(3) The Secretary of Veterans Affairs may not obtain information from the Secretary of Health and Human Services or the Secretary of the Treasury under section 6103(1)(7)(D)(viii) of the Internal Revenue Code of 1986 (as added by subsection (a)) until notification under paragraph (1) is made.

(d) GAO STUDY.—The Comptroller General of the United States shall conduct a study of the effectiveness of the amendments made by this section and shall submit a report on such study to the Committees on Veterans' Affairs and Ways and Means of the House of Representatives and the Committees on Veterans' Affairs and Finance of the Senate not later than January 1, 1992.

SEC. 8052. LINE OF DUTY.

(a) ELIMINATION OF COMPENSATION IN CERTAIN CASES.—Title 38, United States Code, is amended—

(1) in section 105(a), by striking out "the result of the person's own willful misconduct" in the first sentence and inserting in lieu thereof "a result of the person's own willful misconduct or abuse of alcohol or drugs";

(2) in section 310, by striking out "the result of the veteran's own willful misconduct" and inserting in lieu thereof "a result of the veteran's own willful misconduct or abuse of alcohol or drugs"; and

(3) in section 331, by striking out "the result of the veteran's own willful misconduct" and inserting in lieu thereof "a result of the veteran's own willful misconduct or abuse of alcohol or drugs".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect with respect to claims filed after October 31, 1990.

SEC. 8053. REQUIREMENT FOR CLAIMANTS TO REPORT SOCIAL SECURITY NUMBERS; USES OF DEATH INFORMATION BY THE DEPARTMENT OF VETERANS AFFAIRS.

(a) MANDATORY REPORTING OF SOCIAL SECURITY NUMBERS.—Section 3001 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(c)(1) Any person who applies for or is in receipt of any compensation or pension benefit under laws administered by the Secretary shall, if requested by the Secretary, furnish the Secretary with the social security number of such person and the social security number of any dependent or beneficiary on whose behalf, or based upon whom, such person applies for or is in receipt of such benefit. A person is not required to furnish the Secretary with a social security number for any person to whom a social security number has not been assigned.

"(2) The Secretary shall deny the application of or terminate the payment of compensation or pension to a person who fails to furnish the Secretary with a social security number required to be furnished pursuant to paragraph (1) of this subsection. The Secretary may thereafter reconsider the application or reinstate payment of compensation or pension, as the case may be, if such person furnishes the Secretary with such social security number.

"(3) The costs of administering this subsection shall be paid for from amounts available to the Department of Veterans Affairs for the payment of compensation and pension."

(b) REVIEW OF DEPARTMENT OF HEALTH AND HUMAN SERVICES DEATH INFORMATION TO IDENTIFY DECEASED RECIPIENTS OF COMPENSATION AND PENSION BENEFITS.—(1) Chapter 53 of title 38, United States Code, as amended by section 8051(b), is further amended by adding at the end the following new section:

"§ 3118. Review of Department of Health and Human Services death information

"(a) The Secretary shall periodically compare Department of Veterans Affairs information regarding persons to or for whom compensation or pension is being paid with information in the records of the Department of Health and Human Services relating to persons who have died for the purposes of—

"(1) determining whether any such persons to whom compensation and pension is being paid are deceased;

"(2) ensuring that such payments to or for any such persons who are deceased are terminated in a timely manner; and

"(3) ensuring that collection of overpayments of such benefits resulting from payments after the death of such persons is initiated in a timely manner.

"(b) The Department of Health and Human Services death information referred to in subsection (a) of this section is death information available to the Secretary from or through the Secretary of Health and Human Services, including death information available to the Secretary of Health and Human Services from a State, pursuant to a memorandum of understanding entered into by such Secretaries. Any such memorandum of understanding shall include safeguards to assure that information made available under it is not used for unauthorized purposes or improperly disclosed."

(2) The table of sections at the beginning of such chapter, as amended by section 8051(b), is further amended by adding at the end the following:

"3118. Review of Department of Health and Human Services death information."

TITLE IX—TRANSPORTATION

Subtitle A—Surface Transportation

SEC. 9001. SENSE OF CONGRESS THAT HIGHWAY USER TAXES SHOULD BE DEDICATED TO THE HIGHWAY TRUST FUND.

(a) FINDINGS.—Congress finds that—

"(ii) is a student (as defined in section 151(c)(4)) who has not attained the age of 24 as of the close of such calendar year, or

"(iii) is permanently and totally disabled (as defined in section 22(e)(3)) at any time during the taxable year.

"(D) IDENTIFICATION REQUIREMENTS.—

"(i) **IN GENERAL.**—The requirements of this subparagraph are met if—

"(I) the taxpayer includes the name and age of each qualifying child (without regard to this subparagraph) on the return of tax for the taxable year, and

"(II) in the case of an individual who has attained the age of 1 year before the close of the taxpayer's taxable year, the taxpayer includes the taxpayer identification number of such individual on such return of tax for such taxable year.

"(ii) **INSURANCE POLICY NUMBER.**—In the case of any taxpayer with respect to which the health insurance credit is allowed under subsection (a)(2), the Secretary may require a taxpayer to include an insurance policy number or other adequate evidence of insurance in addition to any information required to be included in clause (i).

"(iii) **OTHER METHODS.**—The Secretary may prescribe other methods for providing the information described in clause (i) or (ii).

"(E) ABODE MUST BE IN THE UNITED STATES.—The requirements of subparagraphs (A)(ii) and (B)(iii)(II) shall be met only if the principal place of abode is in the United States."

(b) COORDINATION WITH CERTAIN MEANS-TESTED PROGRAMS.—Section 32 is amended by adding at the end thereof the following new subsection:

"(j) COORDINATION WITH CERTAIN MEANS-TESTED PROGRAMS.—For purposes of—

"(1) the United States Housing Act of 1937,

"(2) title V of the Housing Act of 1949,

"(3) section 101 of the Housing and Urban Development Act of 1965,

"(4) sections 221(d)(3), 235, and 236 of the National Housing Act, and

"(5) the Food Stamp Act of 1977,

any refund made to an individual (or the spouse of an individual) by reason of this section, and any payment made to such individual (or such spouse) by an employer under section 3507, shall not be treated as income (and shall not be taken into account in determining resources for the month of its receipt and the following month)."

(c) ADVANCE PAYMENT OF CREDIT.—Subparagraphs (B) and (C) of section 3507(c)(2) are amended to read as follows:

"(B) if the employee is not married, or if no earned income eligibility certificate is in effect with respect to the spouse of the employee, shall treat the credit provided by section 32 as if it were a credit—

"(i) of not more than the credit percentage under section 32(b)(1) (without regard to subparagraph (D) thereof) for an eligible individual with 1 qualifying child and with earned income not in excess of the amount of earned income taken into account under section 32(a)(1), which

"(ii) phases out between the amount of earned income at which the phaseout begins under section 32(b)(1)(B)(ii) and the amount of income at which the credit under section 32(a)(1) phases out for an eligible individual with 1 qualifying child, or

"(C) if an earned income eligibility certificate is in effect with respect to the spouse of the employee, shall treat the credit as if it were a credit determined under subparagraph (B) by substituting $\frac{1}{2}$ of the amounts of earned income described in such subparagraph for such amounts."

(d) COORDINATION WITH DEDUCTIONS.—

(1) **MEDICAL DEDUCTION.**—Section 213 is amended by adding at the end thereof the following new subsection:

"(f) **COORDINATION WITH HEALTH INSURANCE CREDIT UNDER SECTION 32.**—The amount otherwise taken into account under subsection (a) as expenses paid for medical care shall be reduced by the amount (if any) of the health insurance credit allowable to the taxpayer for the taxable year under section 32."

(2) **SELF-EMPLOYED INDIVIDUALS.**—Paragraph (3) of section 162(l) is amended to read as follows:

"(3) **COORDINATION WITH MEDICAL DEDUCTION, ETC.—**

"(A) **MEDICAL DEDUCTION.**—Any amount paid by a taxpayer for insurance to which paragraph (1) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

"(B) **HEALTH INSURANCE CREDIT.**—The amount otherwise taken into account under paragraph (1) as paid for insurance which constitutes medical care shall be reduced by the amount (if any) of the health insurance credit allowable to the taxpayer for the taxable year under section 32."

(e) CONFORMING AMENDMENTS.—Paragraph (2) of section 32(i) is amended—

(1) by striking "or (ii)" in subparagraph (A)(i) thereof,

(2) by striking "clause (iii)" in subparagraph (A)(ii) and inserting "clause (ii)", and

(3) by amending subparagraph (B) to read as follows:

"(B) **DOLLAR AMOUNTS.**—The dollar amounts referred to in this subparagraph are—

"(i) the \$5,714 dollar amounts contained in subsection (b)(1), and

"(ii) the \$9,000 amount contained in subsection (b)(1)(B)(ii)."

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1990.

SEC. 11112. REQUIREMENT OF IDENTIFYING NUMBER FOR CERTAIN DEPENDENTS.

(a) **GENERAL RULE.**—Paragraph (2) of section 6109(e) (relating to furnishing number for certain dependents) is amended by striking “2 years” and inserting “1 year”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to returns for taxable years beginning after December 31, 1990.

SEC. 11113. STUDY OF ADVANCE PAYMENTS.

(a) **IN GENERAL.**—The Comptroller General of the United States shall, in consultation with the Secretary of the Treasury, conduct a study of advance payments required by section 3507 of the Internal Revenue Code of 1986 to determine—

(1) the effectiveness of the advance payment system (including an analysis of why so few employees take advantage of such system), and

(2) the manner in which such system can be implemented to alleviate administrative complexity, if any, for small business, and

(3) if there are any other problems in the administration of such system.

(b) **REPORT.**—Not later than 1 year after the date of the enactment of this title, the Comptroller shall report the results of the study conducted under subsection (a), together with any recommendations, to the Committee on Finance of the United States Senate and the Committee on Ways and Means of the House of Representatives.

SEC. 11114. PROGRAM TO INCREASE PUBLIC AWARENESS.

Not later than the first calendar year following the date of the enactment of this subtitle, the Secretary of the Treasury, or the Secretary's delegate, shall establish a taxpayer awareness program to inform the taxpaying public of the availability of the credit for dependent care allowed under section 21 of the Internal Revenue Code of 1986 and the earned income credit and child health insurance under section 32 of such Code. Such public awareness program shall be designed to assure that individuals who may be eligible are informed of the availability of such credit and filing procedures. The Secretary shall use appropriate means of communication to carry out the provisions of this section.

SEC. 11115. EXCLUSION FROM INCOME AND RESOURCES OF EARNED INCOME TAX CREDIT UNDER TITLES IV, XVI, AND XIX OF THE SOCIAL SECURITY ACT.

(a) **EXCLUSIONS UNDER TITLE IV.**—

(1) **EXCLUSIONS FROM RESOURCES.**—Section 402(a)(7)(B) of the Social Security Act (42 U.S.C. 602(a)(7)(B)) is amended—

(A) by striking “or” before “(iii)”; and

(B) by inserting “, or (iv) for the month of receipt and the following month, any refund of Federal income taxes made to such family by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income credit), and any payment made to such family by an employer under section 3507 of such Code (relating to advance payment of earned income credit)” before the semicolon.

(2) **EXCLUSIONS FROM INCOME.**—Section 402(a)(18) of the Social Security Act (42 U.S.C. 602(a)(18)) is amended by inserting “or 8(A)(viii)” after “other than paragraph 8(A)(v)”.

(b) **EXCLUSIONS UNDER TITLE XVI.**—

(1) **EXCLUSIONS FROM INCOME.**—Section 1612(b) of the Social Security Act (42 U.S.C. 1382a(b)), as amended by sections 5031(a) and 5035(a) of this Act, is amended—

(A) by striking “and” at the end of paragraph (17);

(B) by striking the period at the end of paragraph (18) and inserting “;and”; and

(C) by adding at the end the following:

“(19) any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit).”.

(2) **EXCLUSIONS FROM RESOURCES.**—Section 1613(a) of the Social Security Act (42 U.S.C. 1382b(a)), as amended by sections 5031(b) and 5035(b) of this Act, is amended—

(A) by striking “and” at the end of paragraph (8);

(B) by striking the period at the end of paragraph (9) and inserting “;and”; and

(C) by adding at the end the following new paragraph:

“(10) for the month of receipt and the following month, any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code (relating to advance payment of earned income credit).”.

(c) **EXCLUSIONS UNDER TITLE XIX.**—Pursuant to section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)), the Secretary of Health and Human Services shall promulgate regulations to exempt from any determination of income and resources (for the month of receipt and the following month) under title XIX of the Social Security Act any refund of Federal income taxes made to an individual by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit), and any payment made to an individual by an employer under section 3507 of such Code (relating to advance payment of earned income credit).

(d) **AFDC WAIVER OF OVERPAYMENT.**—For the purposes of section 402(a)(18) of the Social Security Act (42 U.S.C. 602(a)(18)), a State agency designated under a State plan under section 402(a)(3) of such Act may waive any overpayment of aid that resulted from the receipt by a family of a refund of Federal income taxes by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit) or any payment made to such family by an employer under section 3507 of such Code (relating to advance payment of earned income credit) during the period beginning on January 1, 1990, and ending on December 31, 1990.

(e) **EFFECTIVE DATE.**—The amendments made by subsections (a) through (c) shall apply to determinations of income or resources made for any period after December 31, 1990.

(i) the material terms of which were described in a written public announcement on or before October 9, 1990,

(ii) which was the subject of a prior filing with the Securities and Exchange Commission, and

(iii) which is the subject of a subsequent filing with the Securities and Exchange Commission before January 1, 1991.

PART IV—EMPLOYMENT TAX PROVISIONS

SEC. 11331. INCREASE IN DOLLAR LIMITATION ON AMOUNT OF WAGES SUBJECT TO HOSPITAL INSURANCE TAX.

(a) HOSPITAL INSURANCE TAX.—

(1) **IN GENERAL.**—Paragraph (1) of section 3121(a) is amended—

(A) by striking “contribution and benefit base (as determined under section 230 of the Social Security Act)” each place it appears and inserting “applicable contribution base (as determined under subsection (x))”, and

(B) by striking “such contribution and benefit base” and inserting “such applicable contribution base”.

(2) **APPLICABLE CONTRIBUTION BASE.**—Section 3121 is amended by adding at the end thereof the following new subsection:

“(x) **APPLICABLE CONTRIBUTION BASE.**—For purposes of this chapter—

“(1) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—For purposes of the taxes imposed by sections 3101(a) and 3111(a), the applicable contribution base for any calendar year is the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.

“(2) **HOSPITAL INSURANCE.**—For purposes of the taxes imposed by section 3101(b) and 3111(b), the applicable contribution base is—

“(A) \$125,000 for calendar year 1991, and

“(B) for any calendar year after 1991, the applicable contribution base for the preceding year adjusted in the same manner as is used in adjusting the contribution and benefit base under section 230(b) of the Social Security Act.”

(b) SELF-EMPLOYMENT TAX.—

(1) **IN GENERAL.**—Subsection (b) of section 1402 is amended by striking “the contribution and benefit base (as determined under section 230 of the Social Security Act)” and inserting “the applicable contribution base (as determined under subsection (k))”.

(2) **APPLICABLE CONTRIBUTION BASE.**—Section 1402 is amended by adding at the end thereof the following new subsection:

“(k) **APPLICABLE CONTRIBUTION BASE.**—For purposes of this chapter—

“(1) **OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE.**—For purposes of the tax imposed by section 1401(a), the applicable contribution base for any calendar year is the contribution and

benefit base determined under section 230 of the Social Security Act for such calendar year.

"(2) **HOSPITAL INSURANCE.**—For purposes of the tax imposed by section 1401(b), the applicable contribution base for any calendar year is the applicable contribution base determined under section 3121(x)(2) for such calendar year."

(c) **RAILROAD RETIREMENT TAX.**—Clause (i) of section 3231(e)(2)(B) is amended to read as follows:

"(i) **TIER 1 TAXES.**—

"(I) **IN GENERAL.**—Except as provided in subclause (II) of this clause and in clause (ii), the term 'applicable base' means for any calendar year the contribution and benefit base determined under section 230 of the Social Security Act for such calendar year.

"(II) **HOSPITAL INSURANCE TAXES.**—For purposes of applying so much of the rate applicable under section 3201(a) or 3221(a) (as the case may be) as does not exceed the rate of tax in effect under section 3101(b), and for purposes of applying so much of the rate of tax applicable under section 3211(a)(1) as does not exceed the rate of tax in effect under section 1401(b), the term 'applicable base' means for any calendar year the applicable contribution base determined under section 3121(x)(2) for such calendar year."

(d) **TECHNICAL AMENDMENT.**—

(1) Paragraph (3) of section 6413(c) is amended to read as follows:

"(3) **SEPARATE APPLICATION FOR HOSPITAL INSURANCE TAXES.**—In applying this subsection with respect to—

"(A) the tax imposed by section 3101(b) (or any amount equivalent to such tax), and

"(B) so much of the tax imposed by section 3201 as is determined at a rate not greater than the rate in effect under section 3101(b),

the applicable contribution base determined under section 3121(x)(2) for any calendar year shall be substituted for 'contribution and benefit base (as determined under section 230 of the Social Security Act)' each place it appears."

(2) Sections 3122 and 3125 are each amended by striking "contribution and benefit base limitation" each place it appears and inserting "applicable contribution base limitation".

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to 1991 and later calendar years.

SEC. 11332. COVERAGE OF CERTAIN STATE AND LOCAL EMPLOYEES UNDER SOCIAL SECURITY.

(a) **EMPLOYMENT UNDER OASDI.**—Paragraph (7) of section 210(a) of the Social Security Act (42 U.S.C. 410(a)(7)) is amended—

(1) by striking "or" at the end of subparagraph (D);

(2) by striking the semicolon at the end of subparagraph (E) and inserting "; or"; and

(3) by adding at the end the following new subparagraph:

“(F) service in the employ of a State (other than the District of Columbia, Guam, or American Samoa), of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, by an individual who is not a member of a retirement system of such State, political subdivision, or instrumentality, except that the provisions of this subparagraph shall not be applicable to service performed—

“(i) by an individual who is employed to relieve such individual from unemployment;

“(ii) in a hospital, home, or other institution by a patient or inmate thereof;

“(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

“(iv) by an election official or election worker if the remuneration paid in a calendar year for such service is less than \$100; or

“(v) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 211(c)(2)(E) as a trade or business for purposes of inclusion of such fees in net earnings from self employment; for purposes of this subparagraph, except as provided in regulations prescribed by the Secretary of the Treasury, the term ‘retirement system’ has the meaning given such term by section 218(b)(4);”.

(b) EMPLOYMENT UNDER FICA.—Paragraph (7) of section 3121(b) of the Internal Revenue Code of 1986 is amended—

(1) by striking “or” at the end of subparagraph (D);

(2) by striking the semicolon at the end of subparagraph (E) and inserting “, or”; and

(3) by adding at the end the following new subparagraph:

“(F) service in the employ of a State (other than the District of Columbia, Guam, or American Samoa), of any political subdivision thereof, or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, by an individual who is not a member of a retirement system of such State, political subdivision, or instrumentality, except that the provisions of this subparagraph shall not be applicable to service performed—

“(i) by an individual who is employed to relieve such individual from unemployment;

“(ii) in a hospital, home, or other institution by a patient or inmate thereof;

“(iii) by any individual as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

“(iv) by an election official or election worker if the remuneration paid in a calendar year for such service is less than \$100; or

“(v) by an employee in a position compensated solely on a fee basis which is treated pursuant to section 1402(c)(2)(E) as a trade or business for purposes of in-

clusion of such fees in net earnings from self-employment;

for purposes of this subparagraph, except as provided in regulations prescribed by the Secretary, the term 'retirement system' has the meaning given such term by section 218(b)(4) of the Social Security Act;"

(c) **MANDATORY EXCLUSION OF CERTAIN EMPLOYEES FROM STATE AGREEMENTS.**—Section 218(c)(6) of the Social Security Act (42 U.S.C. 418(c)(6)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting in lieu thereof ", and"; and

(3) by adding at the end the following new subparagraph:

"(F) service described in section 210(a)(7)(F) which is included as 'employment' under section 210(a)."

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to service performed after July 1, 1991.

SEC. 11333. EXTENSION OF FUTA SURTAX.

(a) **IN GENERAL.**—Section 3301 (relating to rate of FUTA tax) is amended—

(1) by striking "1988, 1989, and 1990" in paragraph (1) and inserting "1988 through 1995", and

(2) by striking "1991" in paragraph (2) and inserting "1996".

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to wages paid after December 31, 1990.

SEC. 11334. DEPOSITS OF PAYROLL TAXES.

(a) **IN GENERAL.**—Subsection (g) of section 6302 is amended to read as follows:

"(g) **DEPOSITS OF SOCIAL SECURITY TAXES AND WITHHELD INCOME TAXES.**—If, under regulations prescribed by the Secretary, a person is required to make deposits of taxes imposed by chapters 21 and 24 on the basis of eighth-month periods, such person shall make deposits of such taxes on the 1st banking day after any day on which such person has \$100,000 or more of such taxes for deposit."

(b) **TECHNICAL AMENDMENT.**—Paragraph (2) of section 7632(b) of the Revenue Reconciliation Act of 1989 is hereby repealed.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to amounts required to be deposited after December 31, 1990.

PART V—MISCELLANEOUS PROVISIONS

SEC. 11341. INCREASE IN RATE OF INTEREST PAYABLE ON LARGE CORPORATE UNDERPAYMENTS.

(a) **GENERAL RULE.**—Section 6621 (relating to determination of rate of interest) is amended by adding at the end thereof the following new subsection:

"(c) **INCREASE IN UNDERPAYMENT RATE FOR LARGE CORPORATE UNDERPAYMENTS.**—

"(1) **IN GENERAL.**—For purposes of determining the amount of interest payable under section 6601 on any large corporate underpayment for periods after the applicable date, paragraph (2) of subsection (a) shall be applied by substituting '5 percentage points' for '3 percentage points'.

(3) Section 255(g)(1)(B) of such Act is amended by inserting after the item relating to Railroad retirement tier II the following:

"Railroad supplemental annuity pension fund (60-8012-0-7-602);".

(4) Section 255 of such Act is amended by inserting at the end the following:

"(h) **OPTIONAL EXEMPTION OF MILITARY PERSONNEL.**—

"(1) The President may, with respect to any military personnel account, exempt that account from sequestration or provide for a lower uniform percentage reduction than would otherwise apply.

"(2) The President may not use the authority provided by paragraph (1) unless he notifies the Congress of the manner in which such authority will be exercised on or before the initial snapshot date for the budget year."

(d) **SECTION 256: EXCEPTIONS, LIMITATIONS, AND SPECIAL RULES.**—

(1) Section 256(a) of such Act is amended to read as follows:

"(a) **AUTOMATIC SPENDING INCREASES.**—Automatic spending increases are increases in outlays due to changes in indexes in the following programs:

"(1) National Wool Act;

"(2) Special milk program; and

"(3) Vocational rehabilitation basic State grants.

In those programs all amounts other than the automatic spending increases shall be exempt from reduction under any order issued under this part."

(2) Section 256 of such Act is amended by redesignating subsection (b) as subsection (h), subsection (c) as subsection (b), subsection (e) as subsection (f), subsection (f) as subsection (c), subsection (h) as subsection (i), and subsection (k) as subsection (e), by repealing subsections (i) and (l), and by inserting at the end the following:

"(k) **SPECIAL RULES FOR THE JOBS PORTION OF AFDC.**—

"(1) **FULL AMOUNT OF SEQUESTRATION REQUIRED.**—Any order issued by the President under section 254 shall accomplish the full amount of any required sequestration of the job opportunities and basic skills training program under section 402(a)(19), and part F of title VI, of the Social Security Act, in the manner specified in this subsection. Such an order may not reduce any Federal matching rate pursuant to section 403(l) of the Social Security Act.

"(2) **NEW ALLOTMENT FORMULA.**—

"(A) **GENERAL RULE.**—Notwithstanding section 403(k) of the Social Security Act, each State's percentage share of the amount available after sequestration for direct spending pursuant to section 403(l) of such Act for the fiscal year to which the sequestration applies shall be equal to—

"(i) the lesser of—

"(I) that percentage of the total amount paid to the States pursuant to such section 403(l) for the prior fiscal year that is represented by the amount

paid to such State pursuant to such section 403(l) for the prior fiscal year; or

“(II) the amount that would have been allotted to such State pursuant to such section 403(k) had the sequestration not been in effect.

“(B) **REALLOTMENT OF AMOUNTS REMAINING UNALLOTTED AFTER APPLICATION OF GENERAL RULE.**—Any amount made available after sequestration for direct spending pursuant to section 403(l) of the Social Security Act for the fiscal year to which the sequestration applies that remains unallotted as a result of subparagraph (A) of this paragraph shall be allotted among the States in proportion to the absolute difference between the amount allotted, respectively, to each State as a result of such subparagraph and the amount that would have been allotted to such State pursuant to section 403(k) of such Act had the sequestration not been in effect, except that a State may not be allotted an amount under this subparagraph that results in a total allotment to the State under this paragraph of more than the amount that would have been allotted to such State pursuant to such section 403(k) had the sequestration not been in effect.

“(1) **EFFECTS OF SEQUESTRATION.**—The effects of sequestration shall be as follows:

“(1) Budgetary resources sequestered from any account other than a trust or special fund account shall be permanently cancelled.

“(2) Except as otherwise provided, the same percentage sequestration shall apply to all programs, projects, and activities within a budget account (with programs, projects, and activities as delineated in the appropriation Act or accompanying report for the relevant fiscal year covering that account, or for accounts not included in appropriation Acts, as delineated in the most recently submitted President’s budget).

“(3) Administrative regulations or similar actions implementing a sequestration shall be made within 120 days of the sequestration order. To the extent that formula allocations differ at different levels of budgetary resources within an account, program, project, or activity, the sequestration shall be interpreted as producing a lower total appropriation, with the remaining amount of the appropriation being obligated in a manner consistent with program allocation formulas in substantive law.

“(4) Except as otherwise provided, obligations in sequestered accounts shall be reduced only in the fiscal year in which a sequester occurs.

“(5) If an automatic spending increase is sequestered, the increase (in the applicable index) that was disregarded as a result of that sequestration shall not be taken into account in any subsequent fiscal year.

“(6) Except as otherwise provided, sequestration in trust and special fund accounts for which obligations are indefinite shall be taken in a manner to ensure that obligations in the fiscal year of a sequestration are reduced, from the level that would

actually have occurred, by the applicable sequestration percentage."

(3) Section 256 of such Act is amended by striking "section 252" each place it appears and by inserting "section 254".

(4) Section 256(c) (as redesignated) of such Act is amended by inserting after the first sentence the following: "No State's matching payments from the Federal Government for foster care maintenance payments or for adoption assistance maintenance payments may be reduced by a percentage exceeding the applicable domestic sequestration percentage."

(5) Section 256(d)(1) of such Act is amended to read as follows:

"(1) **CALCULATION OF REDUCTION IN INDIVIDUAL PAYMENT AMOUNTS.**—To achieve the total percentage reduction in those programs required by sections 252 and 253, and notwithstanding section 710 of the Social Security Act, OMB shall determine, and the applicable Presidential order under section 254 shall implement, the percentage reduction that shall apply to payments under the health insurance programs under title XVIII of the Social Security Act for services furnished after the order is issued, such that the reduction made in payments under that order shall achieve the required total percentage reduction in those payments for that fiscal year as determined on a 12-month basis."

(6) Section 256(d)(2)(C) of such Act is repealed.

(e) **THE BASELINE.**—(1) Section 257 of such Act is amended to read as follows:

"SEC. 257. THE BASELINE.

"(a) **IN GENERAL.**—For any budget year, the baseline refers to a projection of current-year levels of new budget authority, outlays, revenues, and the surplus or deficit into the budget year and the outyears based on laws enacted through the applicable date.

"(b) **DIRECT SPENDING AND RECEIPTS.**—For the budget year and each outyear, the baseline shall be calculated using the following assumptions:

"(1) **IN GENERAL.**—Laws providing or creating direct spending and receipts are assumed to operate in the manner specified in those laws for each such year and funding for entitlement authority is assumed to be adequate to make all payments required by those laws.

"(2) **EXCEPTIONS.**—(A) No program with estimated current-year outlays greater than \$50 million shall be assumed to expire in the budget year or outyears.

"(B) The increase for veterans' compensation for a fiscal year is assumed to be the same as that required by law for veterans' pensions unless otherwise provided by law enacted in that session.

"(C) Excise taxes dedicated to a trust fund, if expiring, are assumed to be extended at current rates.

"(3) **HOSPITAL INSURANCE TRUST FUND.**—Notwithstanding any other provision of law, the receipts and disbursements of the Hospital Insurance Trust Fund shall be included in all calculations required by this Act.

"(c) DISCRETIONARY APPROPRIATIONS.—For the budget year and each outyear, the baseline shall be calculated using the following assumptions regarding all amounts other than those covered by subsection (b):

"(1) INFLATION OF CURRENT-YEAR APPROPRIATIONS.—Budgetary resources other than unobligated balances shall be at the level provided for the budget year in full-year appropriation Acts. If for any account a full-year appropriation has not yet been enacted, budgetary resources other than unobligated balances shall be at the level available in the current year, adjusted sequentially and cumulatively for expiring housing contracts as specified in paragraph (2), for social insurance administrative expenses as specified in paragraph (3), to offset pay absorption and for pay annualization as specified in paragraph (4), for inflation as specified in paragraph (5), and to account for changes required by law in the level of agency payments for personnel benefits other than pay.

"(2) EXPIRING HOUSING CONTRACTS.—New budget authority to renew expiring multiyear subsidized housing contracts shall be adjusted to reflect the difference in the number of such contracts that are scheduled to expire in that fiscal year and the number expiring in the current year, with the per-contract renewal cost equal to the average current-year cost of renewal contracts.

"(3) SOCIAL INSURANCE ADMINISTRATIVE EXPENSES.—Budgetary resources for the administrative expenses of the following trust funds shall be adjusted by the percentage change in the beneficiary population from the current year to that fiscal year: the Federal Hospital Insurance Trust Fund, the Supplementary Medical Insurance Trust Fund, the Unemployment Trust Fund, and the railroad retirement account.

"(4) PAY ANNUALIZATION; OFFSET TO PAY ABSORPTION.—Current-year new budget authority for Federal employees shall be adjusted to reflect the full 12-month costs (without absorption) of any pay adjustment that occurred in that fiscal year.

"(5) INFLATORS.—The inflator used in paragraph (1) to adjust budgetary resources relating to personnel shall be the percent by which the average of the Bureau of Labor Statistics Employment Cost Index (wages and salaries, private industry workers) for that fiscal year differs from such index for the current year. The inflator used in paragraph (1) to adjust all other budgetary resources shall be the percent by which the average of the estimated gross national product fixed-weight price index for that fiscal year differs from the average of such estimated index for the current year.

"(6) CURRENT-YEAR APPROPRIATIONS.—If, for any account, a continuing appropriation is in effect for less than the entire current year, then the current-year amount shall be assumed to equal the amount that would be available if that continuing appropriation covered the entire fiscal year. If law permits the transfer of budget authority among budget accounts in the current year, the current-year level for an account shall reflect transfers accomplished by the submission of, or assumed for the

current year in, the President's original budget for the budget year.

"(d) **UP-TO-DATE CONCEPTS.**—In deriving the baseline for any budget year or outyear, current-year amounts shall be calculated using the concepts and definitions that are required for that budget year."

(2) Section 251(a)(6)(I) of such Act (as in effect immediately before the date of enactment of this Act) is redesignated as section 257(e) of such Act. Section 257(e) is amended by striking "assuming, for purposes of this paragraph and subparagraph (A)(i) of paragraph (3), that the" and inserting "The".

(f) Such Act is amended by inserting after section 257 the following:

"SEC. 258. SUSPENSION IN THE EVENT OF WAR OR LOW GROWTH.

"(a) PROCEDURES IN THE EVENT OF A LOW GROWTH REPORT.—

"(1) **TRIGGER.**—Whenever CBO issues a low-growth report under section 254(j), the Majority Leader of the House of Representatives may, and the Majority Leader of the Senate shall, introduce a joint resolution (in the form set forth in paragraph (2)) declaring that the conditions specified in section 254(j) are met and suspending the relevant provisions of this title, titles III and VI of the Congressional Budget Act of 1974, and section 1103 of title 31, United States Code.

"(2) FORM OF JOINT RESOLUTION.—

"(A) The matter after the resolving clause in any joint resolution introduced pursuant to paragraph (1) shall be as follows: 'That the Congress declares that the conditions specified in section 254(j) of the Balanced Budget and Emergency Deficit Control Act of 1985 are met, and the implementation of the Congressional Budget and Impoundment Control Act of 1974, chapter 11 of title 31, United States Code, and part C of the Balanced Budget and Emergency Deficit Control Act of 1985 are modified as described in section 258(b) of the Balanced Budget and Emergency Deficit Control Act of 1985.'

"(B) The title of the joint resolution shall be 'Joint resolution suspending certain provisions of law pursuant to section 258(a)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985.'; and the joint resolution shall not contain any preamble.

"(3) COMMITTEE ACTION.—Each joint resolution introduced pursuant to paragraph (1) shall be referred to the appropriate committees of the House of Representatives or the Committee on the Budget of the Senate, as the case may be; and such Committee shall report the joint resolution to its House without amendment on or before the fifth day on which such House is in session after the date on which the joint resolution is introduced. If the Committee fails to report the joint resolution within the five-day period referred to in the preceding sentence, it shall be automatically discharged from further consideration of the joint resolution, and the joint resolution shall be placed on the appropriate calendar.

"(4) CONSIDERATION OF JOINT RESOLUTION.—

basis of estimates made by the Committee on the Budget of the Senate.”.

(b) **TRANSFER OF BYRD RULE.**—(1) Section 20001 of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by subsection (a), is transferred to the end of title III of the Congressional Budget Act of 1974, and designated as section 313 of that Act.

(2) Section 313 of the Congressional Budget Act of 1974 is amended by—

(A) adding at the beginning the following center heading:

“EXTRANEOUS MATTER IN RECONCILIATION LEGISLATION”;

(B) striking subsection (b), subsection (c), and the last sentence of subsection (a); and

(C) redesignating subsections (d) (e), (f), and (g) as subsections (b), (c), (d) and (e), respectively.

(3) Subsection (a) of the first section of Senate Resolution 286 (99th Congress, 1st Session), as amended by Senate Resolution 509 (99th Congress, 2d Session) is enacted as subsection (c) of section 313 of the Congressional Budget Act of 1974.

(4) Section 313 of the Congressional Budget Act of 1974 is amended—

(A) in subsections (a), (b)(1)(A), and (c), by striking “of the Congressional Budget Act of 1974”;

(B) in subsection (a), by striking “(d)” and inserting “(b)”;

(C) in subsection (b)(2)(C), by adding “or” at the end thereof;

(D) in subsection (c), by striking “when” and inserting “When”;

(E) in subsection (c)(1), by striking “(d)(1)(A) or (d)(1)(D) of section 20001 of the Consolidated Omnibus Budget Reconciliation Act of 1985” and inserting “(b)(1)(A), (b)(1)(B), (b)(1)(D), (b)(1)(E), or (b)(1)(F)”;

(F) in subsection (c)(2), by striking “this resolution” and inserting “this subsection”.

(5) The table of contents for the Congressional Budget and Impoundment Control Act of 1974 is amended by adding after the item for section 312 the following new item:

“Sec. 313. Extraneous matter in reconciliation legislation.”.

Subtitle C—Social Security

SEC. 13301. OFF-BUDGET STATUS OF OASDI TRUST FUNDS.

(a) **EXCLUSION OF SOCIAL SECURITY FROM ALL BUDGETS.**—Notwithstanding any other provision of law, the receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund shall not be counted as new budget authority, outlays, receipts, or deficit or surplus for purposes of—

(1) the budget of the United States Government as submitted by the President,

(2) the congressional budget, or

(3) the Balanced Budget and Emergency Deficit Control Act of 1985.

(b) **EXCLUSION OF SOCIAL SECURITY FROM CONGRESSIONAL BUDGET.**—Section 301(a) of the Congressional Budget Act of 1974 is amended by adding at the end the following: “The concurrent resolution shall not include the outlays and revenue totals of the old age, survivors, and disability insurance program established under title II of the Social Security Act or the related provisions of the Internal Revenue Code of 1986 in the surplus or deficit totals required by this subsection or in any other surplus or deficit totals required by this title.”.

SEC. 13302. PROTECTION OF OASDI TRUST FUNDS IN THE HOUSE OF REPRESENTATIVES.

(a) **IN GENERAL.**—It shall not be in order in the House of Representatives to consider any bill or joint resolution, as reported, or any amendment thereto or conference report thereon, if, upon enactment—

(1)(A) such legislation under consideration would provide for a net increase in OASDI benefits of at least 0.02 percent of the present value of future taxable payroll for the 75-year period utilized in the most recent annual report of the Board of Trustees provided pursuant to section 201(c)(2) of the Social Security Act, and (B) such legislation under consideration does not provide at least a net increase, for such 75-year period, in OASDI taxes of the amount by which the net increase in such benefits exceeds 0.02 percent of the present value of future taxable payroll for such 75-year period,

(2)(A) such legislation under consideration would provide for a net increase in OASDI benefits (for the 5-year estimating period for such legislation under consideration), (B) such net increase, together with the net increases in OASDI benefits resulting from previous legislation enacted during that fiscal year or any of the previous 4 fiscal years (as estimated at the time of enactment) which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, exceeds \$250,000,000, and (C) such legislation under consideration does not provide at least a net increase, for the 5-year estimating period for such legislation under consideration, in OASDI taxes which, together with net increases in OASDI taxes resulting from such previous legislation which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, equals the amount by which the net increase derived under subparagraph (B) exceeds \$250,000,000;

(3)(A) such legislation under consideration would provide for a net decrease in OASDI taxes of at least 0.02 percent of the present value of future taxable payroll for the 75-year period utilized in the most recent annual report of the Board of Trustees provided pursuant to section 201(c)(2) of the Social Security Act, and (B) such legislation under consideration does not provide at least a net decrease, for such 75-year period, in OASDI benefits of the amount by which the net decrease in such taxes

exceeds 0.02 percent of the present value of future taxable payroll for such 75-year period, or

(4)(A) such legislation under consideration would provide for a net decrease in OASDI taxes (for the 5-year estimating period for such legislation under consideration), (B) such net decrease, together with the net decreases in OASDI taxes resulting from previous legislation enacted during that fiscal year or any of the previous 4 fiscal years (as estimated at the time of enactment) which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, exceeds \$250,000,000, and (C) such legislation under consideration does not provide at least a net decrease, for the 5-year estimating period for such legislation under consideration, in OASDI benefits which, together with net decreases in OASDI benefits resulting from such previous legislation which are attributable to those portions of the 5-year estimating periods for such previous legislation that fall within the 5-year estimating period for such legislation under consideration, equals the amount by which the net decrease derived under subparagraph (B) exceeds \$250,000,000.

(b) **APPLICATION.**—In applying paragraph (3) or (4) of subsection (a), any provision of any bill or joint resolution, as reported, or any amendment thereto, or conference report thereon, the effect of which is to provide for a net decrease for any period in taxes described in subsection (c)(2)(A) shall be disregarded if such bill, joint resolution, amendment, or conference report also includes a provision the effect of which is to provide for a net increase of at least an equivalent amount for such period in medicare taxes.

(c) **DEFINITIONS.**—For purposes of this subsection:

(1) The term "OASDI benefits" means the benefits under the old-age, survivors, and disability insurance programs under title II of the Social Security Act.

(2) The term "OASDI taxes" means—

(A) the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1986, and

(B) the taxes imposed under chapter 1 of such Code (to the extent attributable to section 86 of such Code).

(3) The term "medicare taxes" means the taxes imposed under sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1986.

(4) The term "previous legislation" shall not include legislation enacted before fiscal year 1991.

(5) The term "5-year estimating period" means, with respect to any legislation, the fiscal year in which such legislation becomes or would become effective and the next 4 fiscal years.

(6) No provision of any bill or resolution, or any amendment thereto or conference report thereon, involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of OASDI taxes referred to in paragraph (2)(B) unless such provision changes the income tax treatment of OASDI benefits.

SEC. 13303. SOCIAL SECURITY FIREWALL AND POINT OF ORDER IN THE SENATE.

(a) **CONCURRENT RESOLUTION ON THE BUDGET.**—Section 301(a) of the Congressional Budget Act of 1974 is amended by striking “and” at the end of paragraph (4), by striking the period at the end of paragraph (5) and inserting a semicolon; and by adding after paragraph (5) the following new paragraphs:

“(6) For purposes of Senate enforcement under this title, outlays of the old-age, survivors, and disability insurance program established under title II of the Social Security Act for the fiscal year of the resolution and for each of the 4 succeeding fiscal years; and

“(7) For purposes of Senate enforcement under this title, revenues of the old-age, survivors, and disability insurance program established under title II of the Social Security Act (and the related provisions of the Internal Revenue Code of 1986) for the fiscal year of the resolution and for each of the 4 succeeding fiscal years.”

(b) **POINT OF ORDER.**—Section 301(i) of the Congressional Budget Act of 1974 is amended to read as follows:

“(i) It shall not be in order in the Senate to consider any concurrent resolution on the budget as reported to the Senate that would decrease the excess of social security revenues over social security outlays in any of the fiscal years covered by the concurrent resolution. No change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues unless such provision changes the income tax treatment of social security benefits.”

(c) **COMMITTEE ALLOCATIONS.**—

(1) Section 302(a)(2) of the Congressional Budget Act of 1974 is amended by inserting after “appropriate levels of” the following: “social security outlays for the fiscal year of the resolution and for each of the 4 succeeding fiscal years.”

(2) Section 302(f)(2) of the Congressional Budget Act of 1974 is amended by inserting before the period the following: “or provides for social security outlays in excess of the appropriate allocation of social security outlays under subsection (a) for the fiscal year of the resolution or for the total of that year and the 4 succeeding fiscal years”.

(3) Section 302(f)(2) of such Act is further amended by adding at the end the following: “In applying this paragraph—

“(A) estimated social security outlays shall be deemed to be reduced by the excess of estimated social security revenues (including social security revenues provided for in the bill, resolution, amendment, or conference report with respect to which this paragraph is applied) over the appropriate level of social security revenues specified in the most recently adopted concurrent resolution on the budget;

“(B) estimated social security outlays shall be deemed increased by the shortfall of estimated social security revenues (including social security revenues provided for in the bill, resolution, amendment, or conference report with respect to which this paragraph is applied) below the appro-

appropriate level of social security revenues specified in the most recently adopted concurrent resolution on the budget; and
 "(C) no provision of any bill or resolution, or any amendment thereto or conference report thereon, involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues unless such provision changes the income tax treatment of social security benefits.

The Chairman of the Committee on the Budget of the Senate may file with the Senate appropriately revised allocations under subsection (a) and revised functional levels and aggregates to reflect the application of the preceding sentence. Such revised allocations, functional levels, and aggregates shall be considered as allocations, functional levels, and aggregates contained in the most recently agreed to concurrent resolution on the budget, and the appropriate committees shall report revised allocations pursuant to subsection (b)."

(d) POINT OF ORDER UNDER SECTION 311.—(1) Subsection (a) of section 311(a) of the Congressional Budget Act of 1974 is redesignated as subsection (a)(1) and paragraphs (1), (2), and (3) are redesignated as subparagraphs (A), (B), and (C).

(2) Section 311(a) of such Act is amended by inserting at the end the following new paragraph:

"(2)(A) After the Congress has completed action on a concurrent resolution on the budget, it shall not be in order in the Senate to consider any bill, resolution, amendment, motion, or conference report that would cause the appropriate level of total new budget authority or total budget outlays or social security outlays set forth for the first fiscal year in the most recently agreed to concurrent resolution on the budget covering such fiscal year to be exceeded, or would cause revenues to be less than the appropriate level of total revenues (or social security revenues to be less than the appropriate level of social security revenues) set forth for the first fiscal year covered by the resolution and for the period including the first fiscal year plus the following 4 fiscal years in such concurrent resolution.

"(B) In applying this paragraph—

"(i)(I) estimated social security outlays shall be deemed to be reduced by the excess of estimated social security revenues (including those provided for in the bill, resolution, amendment, or conference report with respect to which this subsection is applied) over the appropriate level of Social Security revenues specified in the most recently agreed to concurrent resolution on the budget;

"(II) estimated social security revenues shall be deemed to be increased to the extent that estimated social security outlays are less (taking into account the effect of the bill, resolution, amendment, or conference report to which this subsection is being applied) than the appropriate level of social security outlays in the most recently agreed to concurrent resolution on the budget; and

"(ii)(I) estimated Social Security outlays shall be deemed to be increased by the shortfall of estimated social security revenues (including Social Security revenues provided for in the bill, resolution, amendment, or conference report with

respect to which this subsection is applied) below the appropriate level of social security revenues specified in the most recently adopted concurrent resolution on the budget; and

"(II) estimated social security revenues shall be deemed to be reduced by the excess of estimated social security outlays (including social security outlays provided for in the bill, resolution, amendment, or conference report with respect to which this subsection is applied) above the appropriate level of social security outlays specified in the most recently adopted concurrent resolution on the budget; and

"(iii) no provision of any bill or resolution, or any amendment thereto or conference report thereon, involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues unless such provision changes the income tax treatment of social security benefits.

The chairman of the Committee on the Budget of the Senate may file with the Senate appropriately revised allocations under section 302(a) and revised functional levels and aggregates to reflect the application of the preceding sentence. Such revised allocations, functional levels, and aggregates shall be considered as allocations, functional levels, and aggregates contained in the most recently agreed to concurrent resolution on the budget, and the appropriate committees shall report revised allocations pursuant to section 302(b)."

SEC. 13304. REPORT TO THE CONGRESS BY THE BOARD OF TRUSTEES OF THE OASDI TRUST FUNDS REGARDING THE ACTUARIAL BALANCE OF THE TRUST FUNDS.

Section 201(c) of the Social Security Act (42 U.S.C. 401(c)) is amended by inserting after the first sentence following clause (5) the following new sentence: "Such statement shall include a finding by the Board of Trustees as to whether the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, individually and collectively, are in close actuarial balance (as defined by the Board of Trustees)."

SEC. 13305. EXERCISE OF RULEMAKING POWER.

This title and the amendments made by it are enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such they shall be considered as a part of the rules of each House, respectively, or of that House to which they specifically apply, and such rules shall supersede other rules only to the extent that they are inconsistent therewith; and

(2) with full recognition of the constitutional right of either House to change such rules (so far as relating to such House) at any time, in the same manner, and to the same extent as in the case of any other rule of such House.

SEC. 13306. EFFECTIVE DATE.

Sections 13301, 13302, and 13303 and any amendments made by such sections shall apply with respect to fiscal years beginning on or after October 1, 1990. Section 13304 shall be effective for annual reports of the Board of Trustees issued in or after calendar year 1991.

the House provision. The increase in the maximum penalty for child labor violations responds to the documented need for enhanced enforcement in this area. Raising the maximum level will help deter violations and assist the Department of Labor in its enforcement of the law regulating child labor. According to the Congressional Budget Office, the changes in FLSA child labor civil penalties will produce \$15 million in new federal revenues over the next five years. The FLSA has been modified to specify that these revenues will go to the U.S. Treasury and not to the Department of Labor.

4. National Labor Relations Act penalties

The conferees have agreed to drop the House provision relating to new NLRA civil penalties.

TITLE IV—MEDICARE/MEDICAID

1. Reductions in Payments for Capital-Related Costs of Inpatient Hospital Services for Fiscal Year 1991 (Section 12001 of the House Bill, section 6101 of the Senate amendment)

Present law

Capital-related costs (including depreciation, interest, and rent) are excluded from the prospective payment system (PPS) until September 30, 1991. Until that time, capital costs continue to be reimbursed on a cost basis.

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) reduced payment amounts for capital-related costs by twelve percent for FY 1988 beginning January 1, 1988, and fifteen percent for FY 1989. The Omnibus Reconciliation Act of 1989 (OBRA 1989) reduced payment amounts by fifteen percent for FY 1990, beginning January 1, 1990. Sole community hospitals are exempted from capital-related payment reductions. Current law would pay hospitals 100 percent of their capital-related costs in FY 1991.

House bill

Extends the capital-related payment reduction of 15 percent through FY 1991. Rural primary care hospitals are exempted from the reductions. Extends the exemption of sole community hospitals and essential access community hospitals (EACH) from the payment reductions.

Effective date: Enactment.

Senate amendment

Similar provision, except provides for a 10 percent reduction for capital-related payments attributable to portions of cost reporting periods or discharges occurring from October 1, 1991 and ending September 30, 1995. Requires the Secretary to provide prospective payments for capital-related costs at rates determined in a way that assures that the aggregate payments for such capital-related costs are not greater or less than those that would have been made for portions of cost reporting periods occurring during FY 1992, under the 10 percent capital reduction.

The FY 1991 Continuing Appropriations, H.J. Res. 655, extends the area wage index applicable to hospitals during FY 1990 for discharges occurring on or after October 1, 1990, and before October 20, 1990.

(d) *Permanent Extension of Regional Floor on Standardized Amounts.*—If the regional standardized amount for large urban, other urban, or rural hospitals in a census region is higher than the national standardized amount for such hospitals, payment to those hospitals in that region is based upon 85 percent of the national standardized amount and 15 percent of the regional standardized amount for fiscal years beginning with fiscal year 1988 and ending with fiscal year 1990. This provision is known as the regional floor.

The FY 1991 Continuing Appropriation, H.J. Res. 655, extends the current regional floor on standardized amounts through October 20, 1990.

(e) *Reporting Requirements.*—OBRA 1987 directed the Secretary to develop a uniform hospital reporting demonstration project in two States (the Secretary selected California and Colorado). In those States, hospitals are required to report statistical and cost information using a uniform reporting format developed by the Secretary.

(f) *Responsibilities and Reporting Requirements of Prospective Payment Assessment Commission.*—

(1) *Expansion of Responsibilities.*—The Prospective Payment Assessment Commission (ProPAC) is a 17-member Commission appointed by the Director of the Office of Technology Assessment (OTA). The statutory responsibilities of ProPAC are to: (a) report recommendations to the Secretary of HHS on the appropriate annual increases in standardized amounts and target amounts for inpatient hospital services, and (b) make recommendations to the Secretary on changes in DRG classification or weighting factors and report to Congress its evaluation of any changes made by the Secretary.

(2) *Reporting Requirements for Commission and Secretary.*—

(A) By March 1 of each year, ProPAC is required to report to the Secretary its recommendations for the hospital update factor. In addition, the House Committee on Appropriations has directed ProPAC to submit an annual report to Congress on the impact of PPS on the American health care system; ProPAC currently publishes this report on June 1 of each year.

(B) The Secretary, by March 1 of each year, is required to report to the Congress an initial estimate of the update factor he will recommend for the coming year. By May 1 of each year, the Secretary is required to publish an updated recommendation on the update for public comment, taking ProPAC's recommendation into account; the publication is required to include ProPAC's March 1 report. By September 1, the Secretary is required to publish a final recommendation on the update factor.

(C) The OTA is required to report annually to Congress on the functioning and progress of the Commission.

(3) *Composition of Commission.*—In selecting the ProPAC Commissioners, the Director of the Office of Technology Assessment (OTA) is directed to include national experts, who provide a mix of

different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and registered professional nurses, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care.

(g) *Physician Assistant Hospital Payment Offset.*—OBRA 1986 provided for direct Medicare payment for services of physician assistants and authorized the Secretary to reduce the amount of payments otherwise made to hospitals and skilled nursing facilities in order to avoid duplicate payments for the costs of those services.

(h) *Determination of Reasonable Costs Relating to Swing Beds.*—Reimbursement to hospitals for extended care services in swing beds is limited to the average of the Medicaid skilled nursing facility rates for the State. However, OBRA 87 eliminated in the Medicaid program the distinction between skilled nursing facilities and intermediate care facilities and established a new category of provider, nursing facility.

(i) *Reduction in Indirect Medical Education Payments.*—Medicare pays teaching hospitals an additional amount to reflect the indirect costs associated with graduate medical education programs. Payment for each discharge is increased by approximately 7.65 percent (on a curvilinear basis) for each 10 percent increase in the ratio of interns and residents to beds. The adjustment is scheduled to increase to 8.29 percent in FY 1996, when the disproportionate share adjustment is scheduled to expire.

House bill

(a) *Changes in Hospital Update Factors.*—Provides the following hospital update factors for fiscal years 1991 through 1995: for FY 1991, the market basket minus 2.0 percentage points; for FY 1992, the market basket minus 3.55 percentage points; for FY 1993, the market basket minus 1.0 percentage point; and for FY 1994-1995, the full market basket increase.

(b) *Updates for Rural and Inner-City Hospitals.*—

(1) *Phase-out of Separate Average Standardized Amounts.*—Further amends update factors established in (a), above, adjusting the update for hospitals in rural areas each year by an equal annual factor beginning with FY 1991 and ending with FY 1995, such that the gap between the rural and other urban standardized amounts would be closed by the beginning of FY 1995.

For discharges occurring in a fiscal year beginning on or after October 1, 1995, requires the Secretary to compute two average standardized amounts for hospitals located in large urban areas and for hospitals located in other areas. A single update factor, the market basket increase, will then be applied to hospitals located in both large urban areas and other areas, for discharges occurring in a fiscal year beginning on or after October 1, 1995.

(2) *Disproportionate Share Adjustment.*—(A) Increase for Large Urban Hospitals.—Increases the disproportionate share adjustment for urban hospitals with 100 or more beds by increasing the multiplier in the formulas, phased-in over the following fiscal years: (i) hospitals where the disproportionate patient percentage ("P") is be-

tween 15 and 20.2 percent: for FY 1991, $(P-15).65 + 2.5$; for FY 1992, $(P-15).65 + 2.5$; for FY 1993, $(P-15).7 + 2.5$; for FY 1994, $(P-15).8 + 2.5$; for FY 1995, $(P-15).85 + 2.5$. (ii) hospitals where the disproportionate patient percentage ("P") is over 20.2: for FY 1991 and FY 1992, $(P-20.2).8 + 5.88$; for FY 1993, $(P-20.2).9 + 6.14$; for FY 1994, $(P-20.2).95 + 6.66$; for FY 1995, $(P-20.2) + 6.92$.

(B) Increase for Hospitals With Disproportionate Indigent Care Revenues.—Increases the disproportionate share adjustment for hospitals that qualify on the basis of revenue for indigent care received from State and local governments to 35 percent.

(C) Repeal of the Sunset.—Makes the disproportionate share adjustment permanent. *(D) No Restandardizing for Recent Adjustments.*—(i) Requires that the Secretary not include the additional disproportionate share payments made as a result of the enactment of OBRA 1989; (ii) Requires that the Secretary not include the additional disproportionate share payments made as a result of the enactment of OBRA 1990 when standardizing updated PPS payment amounts.

(c) Phase-in of Area Wage Index.—For fiscal year 1991, requires the Secretary to apply a blended wage index that consists of 75 percent of the area wage index based on the calendar year 1988 survey, and 25 percent of the area wage index as determined using the calendar year 1984 survey. For fiscal years 1992 and 1993, requires the Secretary to apply the new area wage index based on solely the 1988 data.

Requires the Secretary to collect data on compensation and paid hours of employment in each occupational category, including the compensation of contract employees, and provide the data to ProPAC. Using this data, requires the Secretary to analyze and make recommendations to congress on adjusting the area wage index for occupational mix, by June 1, 1993.

(d) Permanent Extension of Regional Floor on Standardized Amounts.—Makes the regional floor permanent. Requires the Secretary to extend the regional floor on a budget-neutral basis.

(e) Reporting Requirements.—Requires hospitals receiving disproportionate share adjustments, regional referral centers, sole community providers, Medicare-dependent small rural hospitals, and EACH facilities to report statistics and cost information using the uniform reporting format developed by the Secretary under the demonstration project.

(f) Responsibilities and Reporting Requirements of Prospective Payment Assessment Commission.—

(1) Expansion of Responsibilities.—

(A) Requires ProPAC, in addition to its other functions, to make recommendations for each fiscal year to the Senate Finance Committee and House Ways and Means Committee on changes in any existing Medicare prospective payment systems for institutional services and on development of new institutional reimbursement policies. Reports are to include recommendations relating to: (a) payment to PPS hospitals, including DRG classification, adjustments for severity, and capital reimbursement, along with recommendations on the effectiveness and quality of U.S. health delivery systems and the effect of Medicare institutional reimbursement; (b) payment to large urban hospitals, including treatment of charity

care and bad debt and the relation between Medicare and programs that pay for services to low-income individuals; (c) payments to rural hospitals, including appropriate responses to problems with low occupancy, quality of care, and access to health care services; and (d) changes in Medicare policies that will constrain the costs of health care to employers.

(B) Eliminates the current requirement for recommendations to the Secretary on DRG weighting factors and a report to Congress evaluating the Secretary's actions.

(2) *Reporting Requirements for Commission and Secretary.*—

(A) Requires ProPAC's March 1 report on the update factor to be submitted to the Senate Committee on Finance and the House Committee on Ways and Means; the report is to include ProPAC's general recommendations on the effectiveness and quality of U.S. health delivery systems. Requires ProPAC to report to the Committees by June 1 preceding each fiscal year on its activities in the preceding fiscal year.

(B) Requires the Secretary, in addition to recommending an update factor, to recommend other changes in existing prospective payment policies, and to include these recommendations in the May 1 and September 1 reports. If the Secretary's recommendations differ from ProPAC's, the May 1 report is required to include an explanation of why ProPAC's recommendations were not followed.

(C) Eliminates the annual OTA report.

(3) *Composition of Commission.*—Provides that the Commissioners are to include a mix of different professions, rather than "professionals," and that the professions may include, but are not limited to, physicians and registered nurses.

(g) *Physician Assistant Hospital Payment Offset.*—Repeals the provision authorizing the Secretary to reduce payments to hospitals and skilled nursing facilities.

(h) *Determination of Reasonable Costs Relating to Swing Beds.*—Provides that payments to hospitals for the routine costs of extended care services in rural areas in a State would be limited to the payments for such costs under the Medicare program for free-standing skilled nursing facilities in such areas in the State. Provides that the limit would be based on costs in the most recent year for which cost reporting data are available trended forward in the same manner as the limits currently applicable to skilled nursing facilities. Further specifies that if this limit reduces payments to hospitals from those received in the previous year, the reasonable cost of the services would be equal to the reasonable cost for the previous year.

(i) *Reduction in Indirect Medical Education Payments.*—No provision.

Effective date: (a) Applies to discharges occurring on or after January 1, 1991. (b)(1) Applies to payments for discharges on or after January 1, 1991; provisions relating to a single standardized amount for rural and other urban areas are effective October 1, 1995. (b)(2) Applies to discharges on or after July 1, 1991, except that the provision relating to changes made by OBRA 1989 is effective as if included in the enactment of OBRA 1989. (c) Enactment. (d) Applies to discharges on or after October 1, 1990. (e) Applies to

cost reporting periods beginning on or after October 1, 1990. (f) Enactment. (g) Effective as if included in the enactment of OBRA 1986. (h) Applies to services furnished on or after October 1, 1990.

Senate amendment

(a) *Change in Hospital Update Factors.*—Provides the following hospital update factors for FY 1991 through 1995: for FY 1991, update the PPS rates by the market basket minus 2 percent; for FY 1992, the market basket minus 1.5 percent; for FY 1993, the market basket minus 1.4 percent; and for FY 1994–1995, the full market basket increase.

(b) *Updates for Rural and Inner-City Hospitals.*—(1) *Phase-out of Separate Average Standardized Amounts.*—Similar provision, except that requires the Secretary to update rural standardized amounts by the full market basket increase during FY 1991–1993. For FY 1994, requires the Secretary to reduce by one-half the percentage difference between the average standardized amount for hospitals in large urban areas or other areas and the average standardized amount for hospitals in rural areas. For FY 1995, the Secretary is required to provide an equal average standardized amount for rural and other urban hospitals by reducing the remainder of the percentage difference between the rural and other urban hospital average standardized amounts.

(2) *Disproportionate Share Adjustment.*—(A) *Increase for Large Urban Hospitals.*—No provision. (B) *Increase for Hospitals With Disproportionate Indigent Care Revenues.*—No provision. (C) *Repeal of the Sunset.*—No provision. (D) *No Restandardizing for Recent Adjustments.*—Similar provision with respect to OBRA 1989 changes.

(c) *Phase-in of Area Wage Index.*—Similar provision. Requires ProPAC to examine State level and other available data measuring earnings and paid hours of employment by occupational category of hospital workers. Requires the analysis to include the impact of variation in occupational mix on the computation of the area wage index. Requires ProPAC to include the findings in its March 1991 report, and make recommendations regarding the feasibility and desirability of modifying the wage index computation to take into account occupational mix data.

(d) *Permanent Extension of Regional Floor on Standardized Amounts.*—No provision.

(e) *Reporting Requirements.*—No provision.

(f) *Responsibilities and Reporting Requirements of Prospective Payment Assessment Commission.*—

(1) *Expansion of Responsibilities.*—

(A) Similar provision, except specifies that reports are to include recommendations relating to: (a) payment to PPS hospitals, including DRG classification, adjustments for severity, and capital reimbursement; and (b) additional payments to hospitals under PPS, including payments to hospitals in large urban and rural areas, including regional referral centers and sole community hospitals, payments for indirect costs of medical education, disproportionate share adjustments, and outlier payments. Further requires that recommendations include recommendations on major revisions to PPS and hospital outpatient payments and recommendations on

payments to PPS-exempt hospitals, skilled nursing facilities, and home health agencies.

(B) Eliminates the requirement for a report to Congress evaluating the Secretary's actions.

(2) *Reporting Requirements for Commission and Secretary.*—

(A) Requires that ProPAC's March 1 report include any additional recommendations developed under section (1), above, relating to institutional reimbursement for the next fiscal year. Requires ProPAC to submit to Congress by June 1 of each year, beginning with calendar 1991, a report examining the American health care system, including cost and utilization trends, the financial condition of hospitals, and new cost containment methods used by private employers and insurers.

(B) Similar provision.

(C) Similar provision.

(3) *Composition of Commission.*—No provision.

(g) *Physician Assistant Hospital Payment Offset.*—No provision.

(h) *Determination of Reasonable Costs Relating to Swing Beds.*—No provision.

(i) *Reduction in Indirect Medical Education Payments.*—Reduces the adjustment to 6.8 percent for FY 1991 through FY 1995, and to 7.4 percent for FY 1996 and later years.

Effective date: (a) Applies to discharges occurring on or after January 1, 1991. (b)(1) Applies to payments for discharges on or after January 1, 1991; provisions relating to a single standardized amount for rural and other urban areas are effective October 1, 1994. (c) Enactment. (i) Applies to payment for discharges occurring on or after January 1, 1991.

2. PPS Hospitals

Conference agreement

(a) *Update Factors.*—The conference agreement includes the Senate amendment providing the following update factors for hospitals, applicable to payments for discharges occurring on or after January 1, 1991: for FY 1991, the market basket percentage increase minus 2.0 percentage points; for FY 1992, the market basket percentage increase minus 1.6 percentage points; for FY 1993, the market basket percentage increase minus 1.55 percentage points; and for FY 1994 and FY 1995, the full market basket percentage increase.

(b) *Updates for Rural and Inner-City Hospitals.*—

(1) *Phase-out of Separate Average Amounts.*—The conference agreement includes the House provision with the following amendments to rural hospital updates: for FY 1991, the market basket minus 0.7 percentage points; for FY 1992, the market basket percentage increase minus 0.6 percentage points; for FY 1993, the market basket percentage increase minus 0.55 percentage points; for FY 1994, the market basket percentage increase plus 1.5 percentage points; and for FY 1995, the market basket percentage increase plus such percentage increase as necessary to provide for the average standardized amount determined to equal the average standardized amount for hospitals located in an urban area (not located in a large urban area).

OBRA 1989 required the Secretary to report to Congress by October 1, 1990 on a legislative proposal to eliminate separate average standardized amounts. The conferees expect the Secretary to deliver a report making recommendations on further modifications needed to affect the elimination of separate average standardized amounts.

(2) *Disproportionate Share Adjustment.*—The conference agreement includes the House provision with amendments. For hospitals with more than 100 beds where the disproportionate patient percent is over 20.2: for discharges occurring on or after January 1, 1991, and before September 30, 1993, (P-20.2) (.7) + 5.88; for discharges occurring on or after October 1, 1993, (P-20.2) (.8) + 6.14. For such hospitals where the disproportionate patient percent is between 15 and 20.2 percentage points: for discharges occurring on or after January 1, 1991, and before September 30, 1993, (P-15) (.65) + 2.5; for discharges occurring on or after October 1, 1993, (P-15) (.7) + 2.5.

In eliminating the sunset on the disproportionate share adjustment, the conferees made a conforming amendment to delete the indirect medical education factor, 8.3 percent, that would have otherwise applied for discharges on or after October 1, 1995, if the disproportionate share adjustment sunset had not been eliminated.

(c) *Phase-in of Area Wage Index.*—The conference agreement includes the Senate amendment, with an amendment requiring the Secretary to pay hospitals using a wage index based solely on the 1988 wage data survey for discharges beginning on January 1, 1991.

The conferees note that the policy adopted through use of the 1984 wage survey data for three months and the use of the 1988 wage survey data for nine months achieves the goal of both bills by creating a 75/25 blend of such data in FY 1991.

(d) *Permanent Extension of Regional Floor on Standardized Amounts.*—The conference agreement includes the House provision, with amendments. The Secretary is required to extend the regional floor until September 30, 1993, and to make payments for discharges occurring during the period beginning October 1, 1990 through October 20, 1990, in a budget neutral manner.

The Secretary is required to collect data on the input prices associated with the non-wage-related portion of the adjusted average standardized amount. The conferees expect that the Secretary will collect the data necessary to create a non-labor cost index; create the index, and evaluate its application to hospital payments; and include the impact of that application on hospitals in the required report to the Congress.

(e) *Reporting Requirements.*—The conference agreement does not include the House provision.

(f) *Responsibilities and Reporting Requirements of Prospective Payment Assessment Commission.*—

(1) *Expansion of Responsibilities:* The conference agreement include the House provision, with amendments, requiring ProPAC to report annually to Congress, by June 1, on trends in health care costs, payment of institutional providers, and new methods of health care cost containment.

(2) **Reporting Requirements for Commission and Secretary:** The conference agreement includes the House provision, with amendments. ProPAC is required to conduct a study of hospital payment rates under State Medicaid programs and report to Congress by not later than October 1, 1991.

(3) **Composition of the Commission:** The conference agreement does not include the House provision.

The conferees note that the purpose of ProPAC is modified to focus on the development of new reimbursement policies and modification of current reimbursement policies which promote the delivery of efficient, accessible, high-quality health care. The Commission would be directed to focus on payments to institutional providers, including hospitals, outpatient departments, skilled nursing facilities, ambulatory surgical centers, and other facilities which may be defined in the future.

In performing this function the conferees intend that ProPAC would include in its analysis and recommendations, proposals for changes in policies regarding: (1) payment of inner-city hospitals, including appropriate recognition of bad debt and charity care costs; (2) payment of rural hospitals including recommendations on appropriate responses to issues affecting access to health care services in rural areas; and (3) policies which help constrain the costs of health care to employers, including changes in Medicare and its payment policies which may affect other payers.

(g) *Physician Assistant Hospital Payment Offset.*—The conference agreement includes the House provision.

(h) *Determination of Reasonable Costs Relating to Swing Beds.*—The conference agreement includes the House bill.

(i) *Reduction in Indirect Medical Education Payments.*—The conference agreement does not include the Senate amendment.

3. Expansion of DRG Payment Window (Section 12003 of the House Bill)

Present law

In order to prevent unbundling of hospital services, all services provided to an inpatient of a hospital are paid through the DRG payment system, although the Secretary may waive this provision in certain isolated circumstances. Outpatient services may not be billed on behalf of an inpatient of a hospital. An inpatient stay is defined as beginning at midnight of the day of admission. The Medicare Intermediary Manual states further that services provided for up to 24 hours prior to the day of admission are considered to be part of the hospital stay and are not separately reimbursable under Part B of Medicare.

House bill

Expands the definition of inpatient operating costs to include services provided on the day of admission and for up to 72 hours prior to a patient's date of admission to a hospital. Such services provided on the day of admission and for up to 72 hours prior to the day of admission would not be separately reimbursable under Part B, if Part A is the primary payer for the admission. Medicare

carriers would be responsible for assuring that payment was not made under Part B for these services.

Effective date.—Applies to services furnished on or after January 1, 1991.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision, with an amendment requiring that the prospective payment system under section 1886(d) include the cost of all services provided during the 72-hour period ending on the date of the patient's admission are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary), for other services furnished on or after October 1, 1991, and for diagnostic services furnished on or after January 1, 1991.

Nothing in this provision requires the Secretary to take special action to adjust the DRG relative weights to reflect the additional services that would be covered by the DRG payment under this provision. The conferees expect that no adjustment will be made before FY 1993 when Part a billing data that would include the additional services would become available to recalibrate the relative weights.

The conferees note that paragraph (b)(1) is simply a statement of current policy as embodied in the intermediary manual. For this reason, the conferees do not expect that there is a need for any further administrative action by the Department to implement this paragraph.

4. PPS-Exempt Hospitals (WM-Section 12005)

Present law

(a) *Reduction in Payment for Capital-Related Costs.*—Certain hospitals are exempt from PPS, including children's hospitals, psychiatric hospitals, rehabilitation hospitals, long-term care hospitals, and cancer hospitals so designated by December 31, 1990 (1991 in Maryland). Reductions in capital-related Medicare payments do not apply to PPS-exempt hospitals.

(b) *Development of National Prospective Payment Rates for Current non-PPS Hospitals.*—Children's hospitals, psychiatric hospitals, rehabilitation hospitals, long-term care hospitals, and cancer hospitals so designated by December 31, 1990 (1991 in Maryland) are exempt from PPS. PPS-exempt hospitals are reimbursed on the basis of reasonable costs, subject to limits known as target amounts, which are defined as the hospital's base-year costs inflated by a rate of increase limit.

(c) *Appeals of Target Amounts.*—

(1) *Deadlines for Review and Decision.*—The Secretary is directed to provide an exemption from, or an exception and adjustment to, a hospital's target rate if events beyond the hospital's control, or extraordinary circumstances, including changes in case mix and volume, or the closure of another hospital, cause a distortion in the hospital's costs. There are no time limits associated with the Secre-

tary's authority. OBRA 1989 required the Secretary to develop a process for hospitals to request exceptions and adjustments. Although the Secretary was required to develop such a process within six months of enactment, the Secretary has not yet developed the process.

(2) *Standards for Assignment of New Base.*—The Secretary may approve the use of a different base year for purposes of determining the appropriate target rate if the new base period is more representative of the reasonable and necessary cost of inpatient services.

(3) *Guidance to Intermediaries and Hospitals.*—No provision.

House bill

(a) *Reduction in Payment for Capital-Related Costs.*—Capital-related costs for PPS-exempt hospitals are reduced by fifteen percent in FY 1991 and 1992.

(b) *Development of National Prospective Payment Rates for Current Non-PPS Hospitals.*—Requires the Secretary to develop a proposal to modify the current system under which PPS-exempt hospitals are reimbursed for the operating costs of inpatient hospital services under Part A, or to replace the current system with a prospective payment system.

In developing a proposal for a prospective payment system, the Secretary is required to: consider the need to provide appropriate limits on increases in Medicare expenditures; provide for adjustments to prospectively determined rates to account for changes in a hospital's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice; consider the need to increase the payment otherwise made under the proposed system for patient cost or length-of-stay outliers; consider the need to increase payments to disproportionate share hospitals, teaching hospitals, and hospitals located in high-wage geographic areas; and, provide for the appropriate allocation of operating and capital-related costs of hospitals and distinct units of such hospitals that would be paid under the new system.

Requires the Secretary to submit the developed proposal to the Senate Committee on Finance and the House Ways and Means Committee by February 1, 1991. Requires the Prospective Payment Assessment Commission (ProPAC) to submit an analysis of and comments on the proposal, by May 1, 1991, to the same committees.

(c) *Appeals of Target Amounts.*—

(1) *Deadlines for Review and Decision.*—Requires that the performance standards and criteria for a fiscal intermediary (an agency or organization that contracts with HCFA to process Part A claims) include the ability to process a completed application of reconsideration of the target amount for a PPS-exempt hospital within 60 days after the application is filed, and, in cases where an incomplete application is received, the ability to return the application with instructions on how to complete the application no later than 60 days after the application is filed.

Requires the Secretary to announce a decision on any request for an exemption, exception, or adjustment not later than 120 days after receiving a completed application of such a request, and in-

clude a detailed explanation of the grounds on which the request was approved or denied.

(2) *Standards for Assignment of New Base Period.*—In making a determination about the assignment of a new base period, requires the Secretary to specifically consider: changes in applicable technologies, medical practices, or case mix severity that increase the hospital's costs; whether increases in wages and wage-related costs in the geographic area in which the hospital is located exceed the average increases in such costs by hospitals nationally; and other factors the Secretary considers appropriate.

(3) *Guidance to Intermediaries and Hospitals.*—Requires the administrator of HCFA to provide guidance to fiscal intermediaries reviewing applications for reconsideration of the target amount and to PPS-exempt hospitals to assist them in filing complete applications.

Effective date: (a) Effective for cost reporting periods beginning on or after October 1, 1990. (b), (c)(1) and (c)(3) effective upon enactment. (c)(2) Effective as if enacted in OBRA 1989.

Senate amendment

(a) *Reduction in Payment for Capital-Related Costs.*—No provision.

(b) *Development of National Prospective Payment Rates for Current Non-PPS Hospitals.*—No provision.

(c) *Appeals of Target Amounts.*—Similar provision, except requires the Secretary to announce a decision on any request for an exemption, exception, or adjustment by not later than 180 days after receiving a completed application, and requires that a detailed explanation of the reason for approval or denial of a request be included.

Effective date: (c) Effective as if included in the enactment of OBRA 1989.

Conference agreement

4. PPS-Exempt Hospitals

Conference agreement

(a) *Reduction in Payments for Capital-Related Costs.*—The conference agreement does not include the House provision.

(b) *Development of National Prospective Payment Rates for Current non-PPS Hospitals.*—The conference agreement includes the House provision, requiring the Secretary to develop a new prospective payment methodology for exempt hospitals, or to modify the target rate system for those hospitals currently exempted from the prospective payment system. In developing this methodology, the conferees expect that the Secretary will consider the special circumstances of some categories of exempt hospitals, such as cancer centers, with technical amendments.

(c) *Appeals of Target Amount.*—The conference agreement includes the Senate amendment, with an amendment, requiring the Secretary to announce a decision on any request for an exemption, exception or adjustment not later than 180 days after the fiscal intermediary receives a completed application.

(d) *Adjustment to Payment Amounts.*—PPS-exempt hospitals shall receive 50 percent of the amount by which their operating costs exceed the target amount. However, these additional payments are subject to a ceiling of 110 percent of the target amount.

The conference agreement includes the provision. The conferees note that the assignment of a new base period falls within the Secretary's discretionary authority to grant exemptions, exceptions, and adjustments to the TEFRA target amount. While the provision requires the Secretary to take into consideration certain factors in determining whether to assign a new base period, the Secretary may take into consideration other factors that might lead to a determination that a new base period is not warranted. In particular, the conferees would not expect that an increase in wage-related costs in the geographic area in which the hospitals are located would exceed the national average increase in such costs as a result of an automatic assignment of a new base period.

5. Freeze in Payments Under Part A through December 31, 1990
(WM-Section 12006)

Present law

Under current law, payments to hospitals are modified in several ways for FY 1991. Payments to hospitals increase by the market basket inflation index; new area wage indices become effective; the regional floor expires; and capital-related costs are reimbursed at 100 percent. Payments to hospices increase by the market basket inflation index. Payments to skilled nursing facilities and home health agencies do not change.

House bill

Freezes payments under Part A at FY 1990 levels through December 31, 1990.

Effective date: November 1, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision, effective from October 21, 1990 through December 31, 1990.

The conferees expect that the Secretary will implement this provision by reducing the standardized amounts published in the Federal Register on September 4, 1990 by the market basket percentage increase of 5.2 percent.

The freeze in the update of the per resident amounts under section 1886(h) will be applied for portions of cost reporting periods occurring during this period. Future updates of such per resident amounts, like the update factor will be made as though the freeze did not occur.

6. Expansion of Hospice Benefit (Section 3112 of House bill, Section 6105 of Senate amendment)

Present law

A Medicare beneficiary who is terminally ill may elect to receive hospice services for two 90-day periods and one subsequent 30-day period, for a total of 210 days during an individual's lifetime. Beneficiaries making this election receive these services in lieu of most other Medicare benefits.

House bill

No provision.

Senate amendment

Provides for a subsequent period of coverage for hospice care, beyond the 210-day limit, if the beneficiary is recertified as terminally ill by the medical director or the physician member of the interdisciplinary group of the hospice program.

Effective date: Applies to care and services furnished on or after January 1, 1990.

Conference agreement

6. Expansion of Hospice Benefit.—The conference agreement includes the Senate amendment.

7. Miscellaneous and Technical Provisions Relating to Part A (Section 6106 of Senate amendment)

Present law

(a) Waiver of Liability for Skilled Nursing Facilities and Hospices.—When a provider furnishes services that are not covered under Medicare, the provider is not normally entitled to Medicare payment for those services. In order for payment to be made to a provider of care, Medicare law requires, at a minimum, that services be medically reasonable and necessary for the diagnosis or treatment of an illness or injury. It also excludes from payment care that is considered to be custodial in nature.

The program, however, has recognized that circumstances may exist where providers of services or beneficiaries could not have reasonably known that services would not be covered. Medicare has paid for a limited number of services which are not medically necessary or are determined to be custodial in nature, so long as it is determined that the provider or beneficiary did not know and could not reasonably have been expected to know that services would be uncovered. The provider is presumed not to know that coverage for certain services would be denied—it qualifies for a “favorable presumption”—when its denial rate is below a certain level. With this favorable presumption, its liability for denied claims below the threshold is waived and it is paid for these claims. The provider receives waiver of liability protection for denied claims below the threshold.

Under the waiver of liability policy for SNFs, facilities with a denial rate of up to 5 percent qualify for favorable presumptive status and are paid for these denied services. If their denial rate

exceeds 5 percent, facilities lose their favorable presumption, and are not automatically paid for their denied claims at or below the 5 percent threshold, and they must argue each claim on a case-by-case basis.

Under the waiver of liability policy for hospices, agencies with a denial rate of up to 2.5 percent qualify for favorable presumptive status and are paid for these denied services. If their denial rate exceeds 2.5 percent, agencies lose their favorable presumption, and are not automatically paid for their denied claims at or below the 2.5 percent threshold, and they must argue each claim on a case-by-case basis.

The skilled nursing facility provision is scheduled to expire October 31, 1990, and the hospice provision is scheduled to expire November 1, 1990.

(b) Designation of Certain Hospitals as Rural Primary Care Hospitals.—

(1) Priority in Discretionary Designations.—OBRA 89 established an Essential Access Community Hospital (EACH) program, under which grants may be made to States to develop rural health networks linking hospitals designated as EACHs with rural primary care hospitals (RPCCHs). In order to qualify for Medicare reimbursement as an RPCH, a facility must be located in a State receiving a grant and must be designated by that State as an RPCH. The Secretary is authorized to designate as RPCHs up to 15 additional facilities that do not meet these requirements.

(2) Eligibility of Certain Closed Hospitals.—A hospital must meet the conditions of participation for a hospital when it applies for designation as an RPCH.

(3) Alternative Criteria for RPCH Designation.—In order to be designated as an RPCH by a State, a facility must have no more than 6 inpatient beds, ordinarily providing inpatient care for periods of no more than 72 hours.

(c) Skilled Nursing Facility Routine Cost Limits.—The Secretary of HHS is authorized to set limits on skilled nursing facility (SNF) routine service costs that will be recognized as reasonable and reimbursed under the program. The Secretary is required to establish separate per diem limits for freestanding and hospital-based SNFs as follows: For freestanding SNFs in urban and rural areas, the limits are set at 112 percent of the mean routine service costs of urban and rural hospital-based facilities, respectively.

Limits for urban and rural hospital-based facilities are set at the appropriate freestanding limit, plus 50 percent of the difference between the freestanding limit and 112 percent of the mean routine service cost for hospital-based facilities. An amount is added to the hospital-based SNFs that is attributable to excess overhead allocations resulting from Medicare reimbursement principles.

The current schedule of Medicare cost limits for SNFs is based on cost reports submitted by SNFs for cost reporting periods ending between October 1, 1982 and September 30, 1983. The Omnibus Budget Reconciliation Act of 1989 included a provision that required the Secretary to use cost reports for cost reporting periods beginning not earlier than October 1, 1985. This provision was not implemented.

(d) Nursing Home Reform Technical Amendments.—

(1) *Nurse Aide Training*.—Effective October 1, 1990, skilled nursing facilities (SNFs) participating in Medicare must use on their staffs as nurse aides only those persons who have completed approved training and competency evaluation programs. Specifically, the law prohibits SNFs from using (on a full-time, temporary, per diem, or other basis) persons as nurse aides for more than 4 months, unless the aide (1) has completed a training and/or a competency evaluation program approved by the State; and (2) is competent to provide nursing or nursing-related services. The law also requires States to establish nurse aide registries of all persons who have satisfactorily completed training and competency evaluation programs and those persons who have been involved in resident neglect and abuse. Nursing homes are required to consult these registries before hiring a person as a nurse aide.

OBRA 87 required the Secretary to establish requirements for State approval of nurse aide training and competency evaluation programs by September 1, 1988, and to specify in these requirements areas to be covered in programs, content of curriculum, minimum hours of initial and ongoing training and retraining, qualification of instructors, and procedures for determining competency. The law prohibits the approval of training and competency evaluation programs offered by a SNF, if the facility has been determined to be out of compliance with requirements for provision of services, residents' rights, and administration. In addition, an amendment included in OBRA 89 prohibits the approval of programs that impose charges for training and competency evaluation.

In 1989, HCFA issued an interim guidance document, effective May 12, 1989, setting out approval criteria for the States. On March 23, 1990, HCFA published a proposed regulation on approval criteria for nurse aide training and competency evaluation programs.

(2) *Period for Resident Assessment*.—OBRA 87 requires that nursing facilities conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be performed promptly upon, but no later than 4 days after, admission to the facility.

(3) *Resident Access to Clinical Records*.—OBRA 87 requires nursing facilities to assure the confidentiality of a resident's personal and clinical records.

(4) *Maintaining Regulatory Standards for Certain Nursing and Related Services*.—OBRA 87 requires SNFs to provide, directly or under arrangements, various kinds of services, including medically-related social services, dietary services, and an on-going program of activities. Final regulations published by HCFA on February 2, 1989, and effective October 1, 1990, specify qualifications for the persons providing these services. These are often different from regulations in effect prior to October 1.

(5) *Ombudsman Program Coordination with State Survey and Certification Agencies*.—States are required to notify State long-term care ombudsman (established under the Older Americans Act) of survey findings of noncompliance with any of the requirements for participation.

(6) *Additional Requirements with respect to Medicare Nurse Staffing Waivers*.—Medicare requires that SNFs provide 24-hour li-

censed nursing care and use a registered professional nurse at least during the day tour of duty (of at least 8 hours a day) 7 days a week. The law authorizes the Secretary to provide waivers to certain rural SNFs for the registered nurse requirement for a 48-hour period.

(e) *ProPAC Study of Medicaid Payments to Hospitals.*—No provision.

(f) *Clarification of Waiver Authority.*—

(1) No provision.

(2) OBRA 1989 authorized the Secretary to waive nursing home survey and certification requirements for one year to test an approved alternative system in Wisconsin.

(g) *Delay in Application to Geographic Classification Review Board.*—OBRA 1989 required the appointment of a Geographic Classification Review Board, to consider appeals by hospitals for a change in classification from rural to urban or from one urban area to another. A hospital requesting such a change for a fiscal year must file its application by the first day of the preceding fiscal year. Guidelines to be used by the Board in evaluating applications were published by the Secretary on September 6, 1990, after the due date for FY 1992 applications.

(h) *Review of Hospital Regulations with Respect to Rural Hospitals.*—OBRA 87 required that the Secretary include a regulatory impact analysis in any notice of proposed rulemaking under Medicare if the rule is expected to have a significant impact on a substantial number of small rural hospitals, and make available a final impact analysis when the final version of such a rule is promulgated.

House bill

No provision.

Senate amendment

(a) *Waiver of Liability for Skilled Nursing Facilities and Hospices.*—Extends waiver of liability protection for skilled nursing facilities and hospices through December 31, 1995.

Effective date: Enactment.

(b) *Designation of Certain Hospitals as Rural Primary Care Hospitals.*—

(1) *Priority in Discretionary Designations.*—Requires the Secretary, in selecting the additional facilities for designation as RPCHs to give priority to hospitals that are not in a grantee State but that are participating in a rural health network in a grantee State.

(2) *Eligibility of Certain Closed Hospitals.*—Authorizes the Secretary to designate a closed hospital as an RPCH if the hospital closed within the last twelve months and the hospital met the conditions of participation at the time it closed.

(3) *Alternative Criteria for RPCH Designation.*—Allows a State to designate as an RPCH a facility that does not meet the 6 bed/72 hour rules but meets alternative limits on number of beds and duration of treatment established by the State.

Effective date: Enactment.

(c) *Skilled Nursing Facility Routine Cost Limits.*—Requires the Secretary to update SNF routine cost limits for cost reporting peri-

ods beginning on or after October 1, 1989, by using cost reports from cost reporting periods ending January 31, 1988 through December 31, 1988. Requires that limits be updated every 2 years beginning on or after October 1, 1992.

Effective date: Effective as if included in OBRA 89.

(d) Nursing Home Reform Technical Amendments.—

(1) Nurse Aide Training.—Includes a number of amendments to nurse aide training and competency evaluation requirements:

(A) No Compliance Actions Before Effective Date of Guidelines.—Prohibits the Secretary from taking (or continuing) any actions against a State for its failure to meet the law's requirements pertaining to competency evaluation through procedures other than passing a written examination before the effective date of regulations issued by the Secretary, if the State demonstrates it has made a good faith effort to meet the requirements before the effective date.

(B) Part-Time Nurse Aides Not Allowed Delay in Training.—Provides that SNFs may not use individuals as nurse aides on a temporary, per diem, or any other basis on or after October 1, 1990, unless the individual meets the training and competency evaluation requirements that apply to full-time aides.

(C) Clarification of Permissible Charges for Training of Aides Not Yet Employed by a Facility.—Permits accredited nonfacility-based nurse aide training and competency evaluation programs to impose charges on individuals who are not presently employed by a nursing facility or who have not yet had an offer for future employment at a facility. Further requires, for individuals employed or under contract for employment as a nurse aide within 12 months after successful completion of a nonfacility-based, State-approved nurse aide training and competency evaluation program, that the State ensure that the costs they incurred for these programs are reimbursed to them.

(D) Nurse Aide Registry.—Requires SNFs, that have reason to believe that a nurse aide they are considering employing is from a State other than the State in which the facility is located, to consult the nurse aide registry of the State where the facility believes the aide resided. Further requires that aides deemed under OBRA 89 to have met the law's training and competency evaluation requirements and those aides for whom the State may waive the competency evaluation requirements under OBRA 89 be added to a State's nurse aide registry.

(E) Clarification of State Responsibility to Determine Competency.—Prohibits States from using subcontracts or other devices to determine that an aide is competent to provide nursing and nursing-related services.

(F) Qualification of Medicare Facilities to Provide Nurse Aide Training and Competency Evaluation.—Provides that a SNF would be ineligible to offer a training and competency evaluation program (1) if at any time on or after October 1, 1988, the facility has been terminated from participation in Medicare or Medicaid, until after the end of a period of at least 2 years during which no survey or investigation finds any deficiencies warranting termination and at least one standard survey has been conducted; or (2) the facility received a notice of termination at any time during the one year

period ending September 30, 1990, until after the completion of a subsequent standard survey which finds no deficiencies warranting the notice; or (3) is found in a standard survey or investigation to have deficiencies resulting in a civil monetary penalty in excess of \$5,000, denial of payment, or appointment of temporary management, until the completion of a subsequent standard survey which finds no deficiencies warranting these sanctions.

(G) *Retraining Required.*—Requires those nurse aides who have not provided services for 24 consecutive months to complete either a nurse aide training and competency evaluation program or a new competency evaluation program.

(2) *Period for Resident Assessment.*—Extends the time limit for a resident's assessment from 4 days to 14 days after admission.

(3) *Resident Access to Clinical Records.*—Adds to this requirement the right to have access to current clinical records, promptly upon the reasonable request (as defined by the Secretary) of the resident or the resident's legal representative.

(4) *Maintaining Regulatory Standards for Certain Nursing and Related Services.*—Requires that any regulations promulgated by the Secretary on medically-related social services, dietary services, and an on-going program of activities be comparable or more strict in their requirements for these services as were regulations for these services prior to the enactment of OBRA 87. Further requires the Secretary to conduct a study on the hiring and dismissal practices of nursing facilities with respect to social workers, dieticians, activities professionals, and medical records practitioners, and report to Congress by January 1, 1993, on whether facilities have on their staffs persons with significantly different credentials as a result of new regulations that became effective October 1, 1990, and the impact of staff composition on quality of care.

(5) *Ombudsman Program Coordination with State Survey and Certification Agencies.*—Requires that State survey agencies enter into a written agreement with the Office of the State Long-Term Care Ombudsman (as defined by the Older Americans Act) to provide for information exchange, case referral, and prompt notification of the office of any adverse action to be taken against a nursing facility.

(6) *Additional Requirements with respect to Medicare Nurse Staffing Waivers.*—Requires the Secretary to provide notice of the waiver to the appropriate State and substate long-term care ombudsman, to the protection and advocacy system and other appropriate State and private agencies, and ensure that a nursing facility that is granted a waiver make reasonable efforts to notify present and prospective residents of the facility (or a guardian or legal representative of residents) of the waiver.

Further requires the Secretary to conduct a study and report to Congress by January 1, 1992, on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for SNFs. Requires that if the Secretary determines that the establishment of minimum ratios is advisable, the report must specify appropriate ratios or standards.

Effective date. Effective as if included in OBRA 87.

(e) *ProPAC Study of Medicaid Payments to Hospitals.*—Requires the Prospective Payment Assessment Commission to conduct a

study of Medicaid hospital payment rates. Requires the study to examine the level of reimbursement under State programs, the relationship between Medicaid and Medicare payments, and the financial condition of affected hospitals, particularly those in urban areas treating large Medicaid and low-income populations. Requires the Commission to report its findings and recommendations to Congress by October 1, 1991.

Effective date: Enactment.

(f) Clarification of Waiver Authority.—

(1) Authorizes the Secretary to waive any provisions of Medicare law that are necessary to conduct a demonstration project for limited-service rural hospitals agreed to before the enactment of OBRA 1989.

(2) Removes the one-year time limit and extends the waiver to other States as part of a nursing home prospective case-mix payment demonstration project.

Effective date: Effective as if included in the enactment of OBRA 1989.

*(g) Delay in Application to Geographic Classification Review Board.—*Provides that an application shall be considered to have been filed by the first day of the preceding fiscal year if submitted within 60 days of the publication of the guidelines.

Effective date: Enactment.

*(h) Review of Hospital Regulations with Respect to Rural Hospitals.—*Requires the Secretary, within 12 months after enactment, to review the impact of Medicare regulations affecting PPS hospitals and determine which could be made less burdensome for rural hospitals without diminishing quality of care; requires that the review include standards related to staffing requirements. Requires the Secretary to report the results to Congress by April 1, 1992, including conclusions on appropriate changes in regulations.

Effective date: Enactment.

7. Miscellaneous and Technical Provisions Relating to Part A

Conference agreement

*(a) Waiver of Liability for Skilled Nursing Facilities and Hospice.—*The conference agreement includes the Senate amendment.

*(b) Designation of Certain Hospitals as Rural Primary Care Hospitals.—*The Conference agreement includes the House provision.

*(c) Skilled Nursing Facility Routine Cost Limits.—*The conference agreement includes the Senate amendment.

*(d) Nursing Home Reform Technical Amendments.—*The managers note that the amendments included below make minor and technical changes to the nursing home reform statute as originally enacted in 1987. The managers are aware that the Secretary will soon issue regulations implementing portions of the original law. The managers do not intend that the amendments below result in any further delay of forthcoming regulations.

(1) Nurse Aide Training.—

*(A) No Compliance Actions Before Effective Date of Guidelines.—*The conference agreement includes the Senate amendment, with an amendment prohibiting the Secretary from taking (or continuing) any actions against a State for its failure to meet the law's re-

quirements for approving nurse aide training and competency evaluation programs before the effective date of guidelines issued by the Secretary, if the State demonstrates it has made a good faith effort to meet the requirements before the effective date.

(B) Part-Time Nurse Aides Not Allowed Delay in Training.—The conference agreement includes the Senate amendment, with a modification to provide that SNFs may not use individuals as nurse aides on a temporary, per diem, leased, or on any other basis other than as a permanent employee, on or after January 1, 1991, unless the individual meets the training and competency evaluation requirements that apply to full-time aides.

(C) Clarification of Permissible Charges for Training of Aides Not Yet Employed by a Facility.—The conference agreement includes the Senate amendment, with an amendment specifying that the prohibition on charging aides would apply to aides who are employed by or who have received an offer of employment from a facility. The conference agreement also includes a modification requiring States to provide for reimbursement of the costs incurred by persons in completing nurse aide training and competency evaluation programs, if they are not employed by or have not received an offer of employment from a facility. These costs would be reimbursed for aides employed within 12 months after completing a program and would be prorated during the period the aide is employed by the facility.

(D) Nurse Aide Registry.—The conference agreement includes the Senate amendment, with amendments. The agreement requires SNFs to consult any State nurse aide registry that the facility believes will include information about an aide. The conference agreement also requires that nurse aides deemed to have met nurse aide training and competency evaluation requirements under OBRA 87 of OBRA 89 and those for whom the State may waive the competency evaluation requirements under OBRA 89 be added to a State's registry. The agreement further prohibits States from imposing any charges on aides for establishing and maintaining the registries.

(E) Clarification of State Responsibility to Determine Competency.—The conference agreement includes the Senate amendment.

(F) Qualification of Medicare Facilities to Provide Nurse Aide Training and Competency Evaluation.—The conference agreement includes the Senate amendment, with an amendment. The agreement prohibits the approval of nurse aide training and competency evaluation programs offered by or in a skilled nursing facility which, within the previous 2 years—(a) has operated under a registered nurse waiver authorized under Medicare; (b) has been subject to an extended (or partial extended) survey under Medicare or Medicaid; or (c) has been subject to sanctions that may be imposed under current law, including a civil money penalty of not less than \$5,000, denial of payment, appointment of temporary management, closing the facility or transferring residents, or termination. For the 2-year period beginning October 1, 1988, the conference agreement also prohibits the approval of nurse aide training and competency evaluation programs offered by or in a nursing facility which (a) has been terminated from participation in Medicaid or Medicare; or (b) has been subject to sanctions that may be imposed

under Medicaid or Medicare or applicable State law, including denial or payment, a civil money penalty of not less than \$5,000, appointment of temporary management, or closing the facility or transferring residents.

(G) *Retraining Required.*—The conference agreement includes the Senate amendment.

(2) *Period for Resident Assessment.*—The conference agreement includes the Senate amendment.

(3) *Maintaining Regulatory Standards for Certain Nursing and Related Services.*—The conference agreement includes the Senate amendment, with a modification to require that any regulations promulgated by the Secretary on medically-related social services, dietary services, and an on-going program of activities include requirements that are at least as strict as those applicable to providers of these services prior to the enactment of OBRA 87. The agreement also deletes the requirement for the Secretary to conduct a study on the hiring and dismissal practices of nursing facilities with respect to social workers, dieticians, activities professionals, and medical records practitioners.

(4) *Ombudsman Program Coordination with State Survey and Certification Agencies.*—The conference agreement includes the Senate amendment, with an amendment to require State survey agencies to notify the Office of the State Long-Term Care Ombudsman of any adverse action taken against a facility under the enforcement section of nursing home reform law.

(5) *Additional Requirements with respect to Medicare Nurse Staffing Waivers.*—The conference agreement includes the Senate amendment, with a modification requiring the Secretary to provide notice of the waiver to the State long-term care ombudsman and the protection and advocacy system in the State for the mentally ill and mentally retarded, and requiring the facility to notify residents (or, where appropriate, the guardians or legal representatives of residents) and members of their immediate families of the waiver.

(6) *Other Amendments.*—The conference agreement includes other amendments:

(A) *Disclosure of Information of Quality Assessment and Assurance Committees.*—The conference agreement provides that a State or the Secretary may not require disclosure of the records of the quality assessment and assurance committee, except for determining the facility's compliance with the requirement for maintaining the committee.

(B) *Resident Access to Clinical Records.*—The conference agreement requires that access to records be provided within 24 hours (excluding hours during a week-end or holiday) after a request. The conference agreement also requires that access be provided to the resident's legal representative.

(C) *Clarification on Findings of Neglect.*—The conference agreement provides that a State can not make a finding of neglect by an individual if the individual demonstrates that neglect was caused by factors beyond the control of the individual.

(D) *Timing of Public Disclosure of Survey Results.*—The conference agreement requires that survey and certification information

be made available to the public within 14 calendar days after this information is made available to the facilities.

(E) *Assurance of Appropriate Payment Amounts.*—The conference agreement requires the Secretary to take into account in payments to SNFs the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each Medicare eligible resident.

(F) *Clarification of Responsibility for Services for Mentally Ill and Mentally Retarded Residents.*—The conference agreement requires that SNFs provide treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

(G) *Clarification of Definition of Nurse Aide.*—The conference agreement clarifies that nurse aides do not include registered dietitians.

(H) *Resident's Rights to Refuse Intra-Facility Transfers.*—The conference agreement provides residents the right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility to a portion that is not. The agreement further provides that a resident's refusal to be transferred will not affect the resident's eligibility for Medicare.

(I) *Inclusion of State Notice of Rights in Facility Notice of Rights.*—The conference agreement requires SNFs to include in the written statement of rights that they are currently required to provide residents, a copy of the State notice of Medicaid rights of residents and spouses of residents.

(e) *Designation of Pediatric Liver Transplant Facilities.*—The conference agreement does not include the House provision.

(f) *ProPAC Study of Medicaid Payments to Hospitals.*—The conference agreement does not include the House provision.

(g) *Clarification of Extension of Waiver for Finger Lakes Area Hospitals Corporation (FLAHC).*—The conference agreement includes the Senate Amendment with an amendment clarifying the FLAHC waiver in OBRA 1989. The conference agreement modifies the test for periodic renewal of the FLAHC waiver to provide that aggregate payments made by Medicare under the FLAHC system since October 1, 1984, are compared to the aggregate payments which would have been made since that date if the hospitals had been paid under the national DRG system.

(h) *Clarification of Secretarial Waiver Authority.*—The conference agreement includes the Senate amendment, with modifications.

(i) *Delay in Application to Geographic Classification Review Board.*—The conference agreement includes provisions from both bills, with a House amendment to clarify the treatment of individual hospitals that are reclassified by the Board. the amendment provides that if the combined impact of all the reclassifications to a given urban area that are effective for this fiscal year reduce the wage index of the urban area by more than one percentage point, the wage index applicable to the hospitals that have been reclassified to the urban area would be determined as if the reclassified hospitals were located in that urban area. The wage data for all

the hospitals that have been reclassified to the same urban area would be combined to determine a single wage index value that would be applicable to those hospitals. In addition, the determination of whether wage data for hospitals that have been reclassified from a rural area to another geographic area should be included in the calculation of the wage index for the rural area based on the combined impact of all the reclassifications from the rural area.

The conference agreement includes a provision from both bills regarding the process for appealing a decision of the Board. The provision was included at the request of the Department of Justice due to concerns about the constitutionality of the relevant provisions of OBRA 1989. The conferees note that even though this provision, struck the first sentence of section 1886(d)(10)(C)(iii)(II), applicants that lose at the Board still must appeal the Board's decision to the Secretary no later than 15 days after the Board renders its decision. The conferees note that concern has been raised regarding the lack of judicial review for decisions of the Secretary concerning decisions of the board. The conferees intend to monitor closely the development of the board and to take appropriate action to provide for such judicial review as necessary. The conference agreement also provides an extension of the application submission deadline for hospitals requesting a change in their geographic classification for FY 1992.

With regard to the interim final rules for the geographic classification review board, the conferees are concerned that the recently promulgated rules do not include guidelines for joint application by hospitals in an urban area classified as other urban to seek reclassification to another urban area classified as large urban. As stated in subsection 6003(h) of OBRA 1989, the Secretary is to develop guidelines "for determining whether the county in which the hospital is located should be treated as being a part of a particular Metropolitan Statistical Area." The statute does not distinguish between rural and urban counties and neither should the Secretary. The omission of guidelines for urban hospitals to seek reclassification as a group is contrary to the intent of Congress in establishing the board and should be rectified at the earliest possible date.

The conferees are also concerned that the thresholds for consideration of applications by the board may be set too high and would urge the Secretary to consider changing them. In particular, the Committee is concerned that the 85 percent criterion for average hourly wages is too high and that the Secretary should consider a threshold of 70 percent for this purpose.

(j) *Review of Hospital Regulations with Respect to Rural Hospitals.*—The conference agreement includes the Senate amendment.

OTHER PART A TECHNICALS

The conference agreement includes the Senate provision with the following amendments:

(a) *Hospital Obligations with Respect to Treatment for Emergency Medical Conditions and Women in Active Labor.*—The conference agreement amends the provisions of the Social Security Act relating to hospital obligations with respect to treatment for emergency medical conditions and women in active labor by:

(1) Clarifying standards for civil money penalties: The conference agreement changes the standard for a civil money penalty for participating hospitals from knowingly violating a requirement of the statute to negligently violate a requirement.

(2) Application of penalties to small hospitals: The conference agreement reduces the maximum civil monetary penalties which could be imposed on a hospital that violates a requirement of the statute with less than 100 beds to \$25,000.

(3) Clarifying standards for terminations of a hospital provider agreement: The conference agreement clarifies standards for termination of a hospital by deleting the provision for hospital termination from section 1867 of the Social Security Act and by providing that hospitals that fail to meet the requirements of section 1867 would be terminated under the provisions of the Social Security Act relating to Medicare conditions of participation. The provisions are effective for actions occurring on or after the first day of the sixth month beginning after enactment.

(b) *Inspector General Study of Prohibition on Hospital Employment of Physicians.*—The conference agreement requires the Secretary of the Department of Health and Human Services, acting through the Inspector General, to conduct a study on the effect of state laws which prohibit the employment of physicians by hospitals on the availability and accessibility of trauma and emergency care services. It further provides that the study include an analysis of the effect of such laws on the ability of hospitals to meet the requirements of section 1867 of the Social Security Act (relating to examination and treatment of individuals with an emergency medical condition and women in active labor), and to assess the impact of such prohibitions on the availability and accessibility of emergency medical care services for Medicare and Medicaid beneficiaries. Requires that the Secretary submit a report to Congress on the study no later than one year after enactment. The provision is effective upon enactment.

(c) *Immediate Enrollment in Part A by Individuals Enrolled in an HOM or CMP.*—The conference agreement includes the House provision with technical amendments.

(d) *Swing Beds Certified Prior to May 1, 1987.*—The conference agreement provides that hospitals that had entered into an agreement to provide extended care services in swing beds prior to May 1, 1987, and would continue to be eligible to do so regardless of whether the area in which the hospital is located is rural or urban.

(e) *Prospective Payment System for Skilled Nursing Facility Services.*—The conference agreement requires the Secretary of HHS to develop for SNF services a proposal to modify or replace the current reimbursement methodology with a prospective payment system.

In developing a prospective payment system, the Secretary is required to (1) take into consideration the need to provide for appropriate limits on increases in expenditures under the Medicare program without jeopardizing access to extended care services for individuals unable to care for themselves; (2) provide for adjustments to prospectively determined rates to account for changes in a facility's case mix, volume of cases, and the development of new technologies and standards of medical practice; (3) take into consideration

the need to increase the payment otherwise made under the new reimbursement system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or costs of treatment provided for under the applicable prospectively determined payment rate; (4) take into consideration the need to adjust payments under the system to take into account factors such as disproportionate share of low-income patients, and differences in wages and wage-related costs in various geographic areas, and other factors the Secretary considers appropriate; and (5) take into consideration the appropriateness of classifying patients and payments upon functional disability, cognitive impairment, and other patient characteristics.

The Secretary (acting through the Administrator of the Health Care Financing Administration) is further required to submit any research studies to be used in developing the proposal to the Senate Finance Committee and the House Ways and Means Committee by April 1, 1991. The Secretary then must submit the SNF prospective payment proposal to the Committee by September 1, 1991, and the Prospective Payment Assessment Commission must submit an analysis of and comments on the Secretary's proposal to the Committees by March 1, 1992.

PART A

8. New Provision—Formerly section 12004 of the House Bill: Payments for Direct Medical Education Costs

SECTION 4004 OF THE CONFERENCE AGREEMENT

Payments for medical education costs

Current law

(a) *Determination of Full-Time-Equivalent Residents.*—Medicare's payment for the direct costs of approved medical education programs (including the salaries of residents and teachers, and other overhead costs directly attributable to the medical education program for training residents, nurses, and allied health professionals) are excluded from PPS. The direct costs of training nurses and allied health professionals are paid on a reasonable costs basis. The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) replaced reasonable cost reimbursement for graduate medical education (residency training programs for physicians) with formula payments based on each hospital's per resident costs. Medicare payments to each hospital are based on the product of: (1) the hospital's approved cost per full-time equivalent (FTE) resident; (2) the weighted average number of FTE residents; and (3) the percentage of inpatient days attributable to Medicare Part A beneficiaries.

Each hospital's per FTE resident amount is calculated using data from a base year, increased by 1 percent for hospital cost reporting periods beginning on or after July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. The number of FTE residents will be calculated at 100 percent after July 1, 1986, only for residents in their initial residency period (defined as the minimum number of years of formal training necessary to satisfy specialty requirements for board eligibility plus 1 year, but not

exceeding 5 years). For residents beyond the initial period of residency, the weighting factor is 0.50 FTE. Foreign medical school graduates are not counted as FTE residents unless they have passed certain designated examinations.

(b) Cap on Approved FTE Resident Amounts.—The approved FTE resident amount for a hospital is equal to the amount determined for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage in the CPI during the 12-month period ending at that midpoint, with adjustments to reflect previous under- or over-estimations in the projected percentage change in the CPI.

(c) Recognition of Costs of Hospital Supported Nursing and Allied Health Education Programs as Allowable Reasonable Costs.—Pursuant to a regulation issued by the Secretary on January 3, 1984, the costs incurred by a hospital for the clinical costs of university-affiliated nursing and allied health education programs are not reimbursable under Medicare.

House bill

(a) Determination of Full-Time-Equivalent Residents.—For residents in their initial residency period, a primary care resident will be counted as 1.1 FTE; a resident specializing in internal medicine or pediatrics will be counted as 1.0 FTE; and all other residents will be counted as 0.75 FTE. For residents beyond the initial period of residency, the weighting factor is increased to 0.80 FTE. Primary care specialties include, family practice medicine, general internal medicine, or general pediatrics.

(b) Cap on Approved FTE Resident Amounts.—The approved FTE resident amount for a hospital is limited to 200 percent of the median of all approved FTE amounts for hospitals for cost reporting periods beginning in FY 1992, adjusted by the area wage index applicable to the hospital; decreasing to 175 percent in FY 1993, and to 150 percent in FY 1994.

(c) Recognition of Costs of Hospital Support Nursing and Allied Health Education Programs as Allowable Reasonable Costs.—No provision.

Senate amendment

(a) Determination of Full-Time-Equivalent Residents.—No provision.

(b) Cap on Approved FTE resident Amounts.—No provision.

(c) Recognition of Costs of Hospital Supported Nursing and Allied Health Education Programs as Allowable Reasonable Costs.—Provides for the reimbursement for clinical costs of university-affiliated nursing programs related to clinical training on a hospital's premises for a hospital supported education program incurred by a hospital or educational institution related to the hospital by common ownership or common control occurring on or after October 1, 1990. Such incurred costs are considered to be for approved educational activities.

Prohibits the Secretary from recouping any alleged overpayments relating to costs which would be allowable under this provision, and to the extent such recoupments have already occurred, to refund the money to the hospitals involved. Directs the Secretary

to audit the hospitals involved to assure that costs of nursing and allied health programs were appropriately reported.

Conference agenda

The conference agreement includes the Senate amendment with modifications. The conferees note that this provision is a further modification of section 6205 of OBRA '89. Payments for hospital-supported programs would be limited to those programs for which a hospital claimed costs and was paid, at least on an interim basis, (as allowable nursing and allied health education costs payable on a reasonable cost basis under section 1861(v)(1)) on its most recent cost reporting period ending on or before October 1, 1989. The conferees note that in the case of hospital-operated nursing and allied health education programs, the Secretary does not recognize costs incurred by a related educational organization as allowable educational costs since such costs are a redistribution of costs from the educational institution to the hospital. Although the provision provides for recognition of the costs incurred by a related educational organization for clinical training on the hospital's premises in the case of a hospital-supported program, the conferees intend that nothing in the provision should be construed as requiring the Secretary to modify his current policy in regard to the determination of reasonable costs for a hospital-operated program.

The conferees note that the Secretary has recently begun to implement the graduate medical education policy enacted in OBRA '85. The conferees expect the Secretary to recoup overpayments identified as a result of implementing this policy over a four year period, after a one year delay. The Secretary may not recoup more than 25 percent of the total amount of such overpayments from a hospital during each of four fiscal years. Nothing in this provision should be construed to require the Secretary to continue to make such overpayments to such hospitals after the initial identification of such an overpayment.

PART B

1. Reduction in Payments for Specific Categories of Physicians Services (Sections 12101-12104 and 4001-4005 and 4013(a) of House bill; Sections 6111-6114 and 6121(c) of Senate amendment)

Present law

(a) Overvalued Procedures.—

(1) Payment Reductions.—OBRA '86 provided for a ten percent across the board reduction in the prevailing charges for cataract surgery. OBRA '87 provided for reductions in the prevailing charges for twelve procedures by two percent plus a sliding scale reduction ranging between zero and fifteen percent. The overvalued procedures were identified by the Physician Payment Review Commission (PPRC).

OBRA '89 provided for reductions in 244 overvalued procedures. Procedures were considered overvalued if the national average prevailing charge exceeded the amount that would be paid under the Resource Based Relative Value Scale (RBRVS) by more than 10 percent, based on the recommendations of the PPRC. The reduc-

tions were equal to one-third of the amount that each procedure was overvalued in each locality, but not more than 15 percent, effective April 1, 1990.

The services considered by the PPRC included 379 codes of the 1,400 procedures studied in the first phase of the Harvard RBRVS study, and did not include any services not in the first phase of that study.

(2) *Definition of Locally Adjusted Reduced Prevailing Amount.*—The calculation of the reduced prevailing charge is based on a comparison with the “locally adjusted reduced prevailing amount.” The “locally-adjusted reduced prevailing amount” for a locality is defined as the product of the “reduced national weighted average prevailing charge” and the “adjustment factor for the locality”. The “reduced national weighted average prevailing charge” is defined as the national weighted average prevailing charge for the service in 1989 (as determined by the Secretary using the best available data) reduced by the applicable 1990 reduction percentage for the service. The “adjustment factor” for a locality as the sum of:

The 1990 practice expense ratio for the service multiplied by the geographic practice cost index value specified for the locality for 1990; and

1 minus the practice expense ratio.

(3) *Unsurveyed Procedures.*—Reductions are only applied to surveyed procedures.

(b) *Payments for Radiology Services.*—

(1) *Payment Rules.*—OBRA '87 required the establishment of a fee schedule for radiology services based on a relative value scale. Payments for radiology services are based on the lesser of 1) actual charges and 2) a local conversion factor times the number of relative value units assigned to the professional and technical components of each procedure. The fee schedule applies to services provided by radiologists (board-certified or board-eligible radiologists, or to physicians for whom one-half of their Medicare charges are for radiology services). OBRA '87 set the radiology payments at 97 percent of the amount allowed under the fee schedule.

An additional reduction in the radiology payments of 4 percent, effective April 1, 1990 was included in OBRA '89. OBRA '89 also eliminated the January 1990 MEI update. Portable x-ray services were exempt from this reduction.

OBRA '89 also provided that most radiology services billed by other physicians could not exceed the payment that would be made under the radiology fee schedule.

When the radiology fee schedule was established, the fee schedule was to be established on the basis of carrier service areas. This has been used by the Secretary to mean carrier localities.

(2) *Certain Screening Services.*—The radiology fee schedule includes professional and technical components for services.

(3) *“Split Billing”.*—Prior to 1989, interventional radiology services were reimbursed based on a method of “split billing” of multiple codes. OBRA '89 authorized a one year extension of this practice.

(4) *Comparability Requirement.*—All services reimbursed on a reasonable charge basis may be reduced by carriers if the carrier's

usual payment in its private business is less than the amount that would otherwise be payable under Medicare.

(5) *Nuclear Medicine Services.*—OBRA 1989 provided a partial exemption from the radiology fee schedule to physicians for whom nuclear medicine services constitute at least 80 percent of their Medicare billings. In 1990, one-third of the payment for nuclear medicine services is based on the fee schedule, with the remaining two-thirds based on 101 percent of the 1988 prevailing charge for the service. In 1991, payment is based on two-thirds of the fee schedule, one-third on the 1988 prevailing charge.

(c) *Payments for Anesthesia Services.*—OBRA '87 provided for the development and establishment of an anesthesiology fee schedule based on a relative value scale for services rendered on or after January 1, 1989. OBRA '86 provided for direct reimbursement for the services of certified registered nurse anesthetists (CRNAs).

OBRA '89 specified that the time units used in computing the relative value units under the relative value schedule would be based on the actual time, rather than rounded up to fifteen or thirty minute time units.

Anesthesiologists are reimbursed for the time they spend supervising anesthesia provided by CRNAs. When supervising multiple concurrent procedures by CRNAs, the amount payable to the anesthesiologists for base units is reduced by 10 percent for two concurrent procedures, 25 percent for three concurrent procedures, and 40 percent for four concurrent procedures.

(d) *Pathology Services.*—OBRA '87 provided for the development of a pathology fee schedule based on a relative value scale that could be used to pay for pathology services. The Secretary was required to submit a report to Congress on the pathology fee schedule. OBRA '89 provided that pathology services provided on or after January 1, 1991 would be paid based on the relative value scale developed by the Secretary.

House bill

(a) *Overvalued Procedures.*—

(1) *Payment Reductions.*—

Section 12101. Provides that prevailing charges for procedures identified as overvalued in OBRA '89 are to be reduced in 1991 by the same amount as such procedures were reduced under OBRA '89. The reduction equals an additional $\frac{1}{3}$, or $\frac{1}{2}$ of the remaining overvalued amount.

Corrects drafting error in OBRA 1989.

Section 4001 and 4013(a). Provides that the prevailing charges for procedures identified as overvalued in OBRA 1989 are to be reduced in 1991 after April 1, by 15 percent, or if less, one-third of the difference between the 1990 prevailing charge and the locally adjusted reduced prevailing amount.

Corrects drafting errors in OBRA 1989.

(2) *Definition of Locally Adjusted Reduced Prevailing Amount.*—

Section 12101. No provision.

Section 4001. Modifies the calculation for 1991 by specifying that the adjustment factor for a locality is the sum of:

The practice component percent, divided by 100, specified in the 1989 committee report, for the service, multiplied by the

geographic practice cost index for the locality as specified in Table 1 of the August 1990 Supplement to the Geographic Medicare Economic Index: Alternative Approaches; and

1 minus the practice component percent multiplied by the geographic physician work adjustment index value which is the geographic $\frac{1}{4}$ work index specified for the locality in such table 1.

Provides that for 1991, in computing the national weighted average, the prevailing charge in each locality must first be deflated by this adjustment factor.

(3) Unsurveyed Procedures.—

Section 12101. Provides for a 5 percent reduction in 1991 in prevailing charges for nonsurveyed physicians services except for the following:

Radiology, anesthesia and physician pathology services and services identified as overvalued in OBRA 1989;

Primary care services, hospital visits, consultations, second and third surgical opinions, preventive medicine visits, ophthalmology visits, psychiatric services, emergency care facility services, and critical care services;

Partial, simple and subcutaneous mastectomy, tendon sheath injections and small joint arthrocentesis, femoral fracture and trochanteric fracture treatments, endotracheal intubation, thoracentesis, thoracostomy, lobectomy, aneurysm repair, enterectomy, colectomy, cholecystectomy, cystourethroscopy, transurethral fulguration and resection, sacral laminectomy, tympanoplasty with mastoidectomy, and ophthalmoscopy.

Section 4005. Provides for a 2 percent reduction in the prevailing charge otherwise recognized for all physicians services (and 4 percent for services paid on a global basis) except for the following:

Radiology, anesthesia, and physician pathology services, and services identified as overpriced in OBRA 1989;

Primary care services, hospital inpatient medical services, consultations, preventive medicine visits, emergency care facility services, and critical care services;

Procedure codes specified in the conference report for OBRA 1990 for tendon sheath injections and small joint arthrocentesis, femoral fracture and trochanteric fracture treatments, endotracheal intubation, thoracentesis, thoracostomy, and transurethral fulguration and resection.

(b) Payments for Radiology Services.—

(1) Payment Rules—

Section 12102. Provides that the local conversion factors used for payments under the radiology fee schedule are reduced by up to fifteen percent in 1991. The amount of the reduction in each locality is calculated as follows:

The national weighted average conversion factor that applied after April 1, 1990 is reduced by six percent;

A local reduced conversion factor is calculated as the sum of:

(i) the product of the reduced national weighted average conversion factor attributable to the physician work component and the geographic work index value for the locality; and (ii) the product of the remaining portion of the reduced national weighted average conversion factor and the geographic work

index value. In the case of a professional fee (or the professional component of a global fee), 80 percent of the conversion factor is considered attributable to the physician work component. In the case of a technical fee, the percentage is 35 percent. The adjustments are the same as those that would apply under RBRVS.

Provides that the local conversion factor is reduced to the adjusted local amount, up to a maximum reduction of fifteen percent. If the local conversion factor is less than the adjusted local amount, the local conversion factor would not change.

Specifies that the prevailing charges of radiology services not reimbursed under the fee schedule would be reduced to the fee schedule amount.

Specifies that the fee schedule is established on the basis of localities.

Section 4002. Provides that the reduction may be up to 8 percent. The calculation of the 1991 conversion factor used in a locality is determined as follows:

The Secretary is required to estimate the national weighted average of the conversion factors used in 1990. In making this calculation, the conversion factor in each locality is first deflated by the sum of $\frac{3}{4}$ of the specific 1990 locality index and $\frac{1}{4}$ of the fee schedule geographic index for the locality. This amount is to be reduced by 11 percent.

The Secretary is required to establish a 1990 locality index which reflects for each locality the ratio of the local conversion factor to the national weighted average.

The Secretary is required to establish a fee schedule geographic index value for each locality equal to the geographic adjustment factor which would be used under the fee schedule if: (1) the work, overhead, and malpractice expense indices contained in the published model fee schedule were used, and (2) the proportions that each component represented of the total relative value were the same as that specified for radiology in such model schedule.

The Secretary is to apply a locality conversion factor based on the product of: (1) the reduced national weighted average conversion factor; and (2) the sum of $\frac{3}{4}$ of the specific 1990 locality index and $\frac{1}{4}$ of the fee schedule geographic index for the locality.

Specifies that the geographic adjustment is phased-in such that in 1992, the 1990 locality index represents $\frac{1}{2}$ in the calculation with the amount otherwise calculated under the fee schedule representing the other half. In 1993, $\frac{3}{4}$ is based on the fee schedule calculation and $\frac{1}{4}$ on the 1990 locality index.

Specifies that the fee schedule may be developed on a locality basis.

(2) Certain Screening Services.—

Section 12102. Reduces by 10 percent, effective for services furnished after Dec. 31, 1990, the relative values established for magnetic resonance imaging (MRI) services and computer assisted tomography (CAT) services.

Section 4002. No provision.

(3) "Split Billing".—

Section 12102. No provision.

Section 4002. Extends the "split billing" provision for interventional radiology services for an additional year, until January 1, 1992.

(4) *Comparability Requirement.*—

Section 12102. No provision.

Section 4002. Prohibits carriers from applying the comparable fee rule to services under the radiology fee schedule.

(5) *Nuclear Medicine Services.*—

Section 12102. No provision.

Section 4002. Provides that the 1990 payment rules apply in 1991.

(c) *Payments for Anesthesia Services.*—

Section 12103. Reduces the local conversion factors used for payments for anesthesia services by up to fifteen percent in 1991. The amount of the reduction in each locality is calculated as follows:

The national weighted average conversion factor that applied after April 1, 1990 is reduced by six percent;

A local reduced conversion factor is calculated as the sum of:

(i) the product of the reduced national weighted average conversion factor attributable to the physician work component and the geographic work index value for the locality; and (ii) the product of the remaining portion of the reduced national weighted average conversion factor and the geographic practice cost index value. Seventy percent of the conversion factor is considered attributable to the physician work component. The adjustments are the same as those that would apply under RBRVS.

Provides that the local conversion factor is reduced to the adjusted local amount, up to a maximum reduction of fifteen percent. If the local conversion factor is less than the adjusted local amount, the local conversion factor would not change.

Extends the reduction in payments to anesthesiologists for supervising multiple concurrent services by CRNAs through December 31, 1995.

Section 4003. Provides that the reduction may be up to 15 percent. The Secretary is required to calculate a 1991 conversion factor to be used in a locality as follows:

The Secretary is required to estimate the national weighted average of conversion factors used in 1990. This amount is first to be deflated by the sum of $\frac{1}{2}$ of the specific 1990 locality index and $\frac{1}{2}$ of the fee schedule geographic index for the locality. This amount is reduced by 7 percent.

The Secretary is required to establish a 1990 index which reflects for each locality the ratio of the local conversion factor to the national weighted average.

The Secretary is required to establish an index value for each locality equal to the geographic adjustment factor which would be used under the fee schedule if: (1) the work, overhead, and malpractice expense indices contained in the published model fee schedule were used, and (2) the proportion of the total relative value for the work component was 55.9 percent, for the practice expense component—33.4 percent, and for the malpractice component—10.7 percent.

The Secretary is to apply a locality conversion factor based on the product of: (1) the reduced national weighted average conversion factor; and (2) the sum of $\frac{1}{2}$ of the 1990 index for the locality and $\frac{1}{2}$ of the RVS index value.

Extends the provision providing for reduction for supervision of concurrent services through December 31, 1995.

Contains no provision relating to the comparable fee rule.

(d) Pathology Services.—

Section 12104. Repeals the requirement to implement the pathology fee schedule and the requirement for the Secretary to submit a report to Congress on the pathology fee schedule.

Specifies that the prevailing charge for anatomic pathology services furnished on or after January 1, 1991 is to be 94 percent of the amount otherwise determined for 1990 after April 1 (taking into account OBRA 1990 amendments).

Section 4004. Repeals requirement to implement a pathology fee schedule but not the one requiring the Secretary to submit a report on a pathology fee schedule.

Specifies that the prevailing charge for physician pathology services furnished during 1991, is 93 percent of the amount used in 1990.

Effective date:

Sections 12101-12104. (a) Apply to services furnished after December 1990, except for the OBRA 1989 technical correction which applies to services furnished after March 1990. (b) Effective January 1, 1991, except for the provision relating to payment localities which is effective as if included in OBRA 1987. (c) and (d) Enactment.

Sections 4001-4005 and 4013(a). (a) and (c) Enactment. (b) Except as otherwise provided, applies to services furnished on or after January 1, 1991; provision authorizing locality adjustments to fee schedules applies to services performed on or after April 1, 1989. (d) Applies to services furnished on or after January 1, 1991.

Senate Amendment

(a) Overvalued Procedures.—

*(1) Payment Reductions.—*Similar to Section 4001.

*(2) Definition of Locally Adjusted Reduced Prevailing Amount.—*Modifies the calculation for 1991 by specifying that the adjustment factor for a locality is the sum of:

The 1990 practice expense component percent (divided by 100) for the service multiplied by the geographic practice cost index value specified for the locality for 1990; and

1 minus the practice expense component percent (divided by 100) for the service multiplied by the geographic work index value specified in the published model fee schedule.

*(3) Unsurveyed Procedures.—*Similar to WM provision except provides for a 4 percent reduction. Does not include second and third surgical opinions, ophthalmology visits, or psychiatric services in the excluded list.

(b) Payments for Radiology Services.—

(1) Payment Rules.—

Similar to Section 12102 except (1) the Secretary is required to adjust the conversion factor for each locality by the adjustment

factor for purposes of determining the national weighted average conversion factor; (2) the reduction in the national weighted average conversion factor is 12 percent; (3) the maximum reduction is 8 percent; and (4) in applying this calculation to global fees, the conversion factor to be applied is the sum of the conversion components for the professional and technical components computed separately.

Specifies that the prevailing charges of radiology services not reimbursed under the fee schedule are to be reduced to the fee schedule amount with the exception of nuclear medicine services and services subject to the OBRA 1989 provision limiting prevailing charges for services furnished by more than one specialty.

Provides that for the purposes of determining radiology payments in 1991 (and the adjusted historical payment basis), the Secretary is to establish a locality specific conversion factor floor that is equal to 80 percent of the national weighted average of the conversion factors used in 1990 (beginning in April) adjusted for the locality as specified above. The conversion factor applied in a locality in 1991 (and the adjusted historical payment basis) may not be less than this floor.

(2) *Certain Screening Services*.—No provision.

(3) *"Split Billing"*.—Identical to Section 4002.

(4) *Comparability Requirement*.—Prohibits carriers from applying the comparable fee rule to services under the radiology fee schedule.

Prohibits inherent reasonableness adjustments under the radiology fee schedule.

(5) *Nuclear Medicine Services*.—Similar to Section 4002. Further, provides that the special payment amounts for 1990 (after Mar. 31) and 1991 are to be used instead of the weighted average prevailing charge amount in the calculations of the adjusted historical payment basis.

Provides that for purposes of determining the fee schedule amount for nuclear medicine services furnished on or after Jan. 1, 1992, the Secretary is to determine relative values in accordance with the methodology used for other physicians services; relative values developed under the radiology fee schedule may not be applied.

(c) *Payments for Anesthesia Services*.—Reduces the local conversion factors used for payments for anesthesia services by up to fifteen percent in 1991. The amount of the reduction in each locality is calculated as follows:

The national weighted average conversion factor that applied after April 1, 1990 is calculated. For this calculation, the Secretary is required to adjust the conversion factor for each locality by the adjustment factor;

The national weighted average conversion factor is reduced by four percent;

A local reduced conversion factor is calculated as the sum of: (i) the product of the portion of the reduced national average conversion factor attributable to the physician work and the geographic work index value for the locality published in the model fee schedule; and (ii) the product of the remaining portion of the reduced national weighted average conversion

factor and the geographic practice cost index value specified for the locality. Seventy percent of the conversion factor is considered attributable to the physician work component.

Provides that for the purposes of determining physician anesthesia payments in 1991 (and the adjusted historical payment basis for 1992-1994), the Secretary is to establish a locality specific conversion factor floor that is equal to 75 percent of the national weighted average of the conversion factors used in 1990 (beginning in April) adjusted for the locality as specified above. The conversion factor applied in a locality in 1991 (and the adjusted historical payment basis) may not be less than this floor.

Extends the reduction in payments to anesthesiologists for supervising multiple concurrent services by CRNAs through December 31, 1995.

Contains no provision relating to the comparable fee rule.

(d) *Pathology Services*.—Similar to WM provision except the prevailing charge is equal to 96 percent of the 1990 prevailing charge.

Limits reductions in the prevailing charge for the technical and professional components of an anatomic pathology service furnished by a physician through an independent laboratory. The reduction can not reduce the prevailing charge below 115 percent of the prevailing charge for the professional component of the service when provided by a hospital-based physician. For purposes of the limit, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians office.

Requires the Secretary to provide an appropriate payment adjustment to reflect the technical component of furnishing physician pathology services through an independent laboratory. The adjustment applies to services furnished on or after Jan. 1, 1992. For purposes of the adjustment, an independent laboratory is a laboratory that is independent of a hospital and separate from the attending or consulting physicians office.

Effective date: Enactment.

Conference agreement

(a) *Overpriced Procedures*.

(1) *Payment Reductions*.—The Conference agreement includes Section 12101 of the House provision.

(2) *Definition of Locally Adjusted Reduced Prevailing Amount*.—The Conference agreement does not include this provision.

(3) *Unsurveyed Procedures*.—The conference agreement includes Section 12101 of the House bill with an amendment deleted certain procedures from the excluded list. Technical procedures which are subject to the new limitation on the technical component for diagnostic tests are excluded from the reduction under this provision. Further, the reduction in prevailing charges for unsurveyed procedures is set at 6.5 percent.

(b) *Payments for Radiology Services*.—

(1) *Payment Rules*.—The conference agreement includes the Senate provision with an amendment. The agreement provides that the amount of the conversion factor in each locality is calculated as follows. The Secretary is to estimate the national weighted average conversion factor for services furnished in 1990 and reduce that

amount by 13 percent. Prior to calculating the national weighted average, the conversion factor in each locality is first to be deflated by the sum of $\frac{1}{2}$ of the locally adjusted amount and $\frac{1}{2}$ of the GPCI adjusted amount.

The Secretary is required to establish a local index for each locality. For 1991, the conversion factor applied in a locality to the professional or technical component of a service is the sum of $\frac{1}{2}$ of the locally adjusted amount and $\frac{1}{2}$ of the GPIC-adjusted amount.

The locally-adjusted amount is defined as the product of the reduced national weight average conversion factor and the 1990 index established for the locality.

The GPCI-adjusted amount is defined as the sum of two items. The first represents the product of the portion of the reduced national weighted average conversion factor attributable to physician work and the geographic index value for the service as published in the model fee schedule. The second represents the product of the remaining portion of the reduced national average conversion factor and the geographic practice cost index value for the locality.

The agreement specifies that in applying these factors to the professional component of a service, 80 percent is attributable to physician work. With respect to the technical component, 0 percent is attributable to physician work.

The agreement provides that the maximum adjustment in the conversion factor is 9.5 percent.

The agreement further provides for a special transition rule to the fee schedule for radiology services.

(2) *Certain Screening Services.*—The conference agreement includes the House provision with an amendment specifying that the amount otherwise payable for specified services is reduced by ten percent.

(3) *Spit billing.*—The conference agreement includes the Senate amendment.

(4) *Comparability Requirement.*—The conference agreement includes the Senate amendment.

(5) *Nuclear Medicine Services.*—The conference agreement includes the Senate amendment with an amendment striking the language relating to determination of relative values for 1992 and thereafter.

(c) *Payments for Anesthesiology Services.*—The conference agreement includes the Senate amendment with an amendment specifying that the reduction in the national weighted average conversion factor is seven percent.

(d) *Pathology Services.*—The Conference agreement includes Section 4004 of the House provision with an amendment providing a limitation on reductions for services furnished by a physician through an independent laboratory to the extent the reduction would reduce the prevailing charge below 115 percent of the prevailing charge for the professional component of such physician when furnished by a hospital-based physician in the same locality. Require the Secretary to provide an appropriate adjustment to reflect the technical component for furnishing physician pathology services through an independent laboratory.

2. Payments for Physicians Services (Section 12105 and 4006 of House bill; Section 6115 of Senate amendment)

Present law

(a) *Update.*—Customary and prevailing charge screens, fee schedules and limits on actual charges are scheduled to be updated on January 1 of each year. In general, prevailing charges are updated by the percentage change in the Medicare Economic Index (MEI).

OBRA '89 delayed the annual update to April 1, 1990. Primary care services were updated by 4.2 percent, the full amount of the MEI. The update for other services was two percent, except for radiology, anesthesiology, and services identified in OBRA '89 as overvalued which were not updated.

(b) *Physician Medicare Volume Performance Standards.*—OBRA '89 established a system of Medicare Volume Performance Standards (MVPSs) which is used for calculating the annual update in fees (conversion factor) for physician and certain other Part B services on or after January 1, 1992. Under this system, Congress would enact a specific level of increase in expenditures for a subsequent calendar year. In the absence of Congressional action, the rate of increase in expenditures is determined by a formula specified in law. The formula sets the allowed increase in expenditures under the MVPS equal to the sum of: (1) the percentage increase in fees; (2) the increase in number of Part B enrollees, excluding HMO risk-contracting enrollees; (3) an estimate of the historical rate of increase in volume of services; (4) any change in expected payments due to legislation or regulations; and (5) reduced by an amount equal to 0.5 percent for the year 1991, 1 percent for 1992, 1.5 percent for 1993, and 2 percent thereafter.

The update or conversion factor for the second calendar year beginning after the close of the year for which a volume performance standard is set is equal to the MEI, adjusted by the amount by which expenditures exceed or are under the standard, subject to certain limits specified in law.

Beginning in 1990, the MVPS provides for two separate standards to be established, one for surgical services, and one for all others.

(c) *Revise Authority for PPRC.*—The Physician Payment Review Commission (PPRC) was established in COBRA. Current law provides that the Commission's membership includes a variety of health professionals, researchers and representatives of consumers and the elderly.

Since it was established, the primary responsibility of the Commission has been the development of a physician payment reform proposal. Congress enacted payment reform in OBRA '89.

(d) *Transition to the RBRVS for Primary Care Services.*—The prevailing charges for primary care services are subject to a lower limit equal to 50 percent of the national average prevailing charge for participating physicians for such services. This lower limit is known as the "primary care floor."

For all physician services, the transition to the RBRVS beginning in 1992 is based on an amount known as the "adjusted historical payment basis." This is defined as the weighted average prevailing charge applied in the locality in 1991, adjusted to reflect

payments for services at amounts below the prevailing charge. The historical payment basis is determined without regard to physician specialty.

House bill

(a) Update.—

Section 12105. Specifies that the MEI update that applies in 1991 is equal to the full MEI for primary care services, and 0 percent for all other services. For 1992, the MEI otherwise applicable is reduced by 0.4 percent.

Section 4006. Specifies that the MEI update for 1991 is equal to the full MEI for primary care services and 0 percent for all other services.

(b) Physician Medicare Volume Performance Standards.—

Section 12105. Specifies that the MVPS for surgical services, non-surgical services, and overall is set by a formula equal to the sum of the percentage growth in Part B enrollees (excluding HMO enrollees), the historical percentage growth in volume, and the percentage change in expected expenditures due to the provisions included in OBRA 1990 and any regulations issued by the Department which would effect the growth in expenditures for services covered by the MVPS system, minus an adjustment factor.

Provides that the same historical rates of growth in volume and growth in number of beneficiaries are used for surgical, nonsurgical, and overall categories of services. The adjustment factor is minus 1 percent in 1991, minus 1.5 percent in 1992, minus 2 percent in 1993, 1994, and 1995.

Specifies that the component reflecting changes in expenditures due to OBRA 1990 provisions varies between surgical and nonsurgical categories by the relative impact of the bill on expenditures for these two categories.

Section 4006. No provision.

(c) Revise Authority for PPRC.—

Section 12105. Revises PPRC responsibilities. Repeals requirements relating to development of a relative value scale and requirements for PPRC to consider various issues related to the reasonable charge payment system.

Amends current provision requiring PPRC to consider policies under Medicare to include: (1) major issues in the implementation of the RBRVS; (2) issues relating to further development of the volume performance standard system, including continuing development of State-based programs; (3) payment incentives to increase access to primary care and other services in innercity and rural areas, including Federal policies regarding the level of Medicaid payments to physicians; (4) the number and types of physicians being trained, including consideration of Medicare graduate medical education policy; (5) utilization review and quality of care, including revisions to the PRO and other Medicare quality assurance programs, and physician licensing and certification; and (6) options to help constrain the costs of health care to employers, including incentives under Medicare. In addition, requires PPRC to make recommendations regarding reforms in medical malpractice and physician licensing and certification.

Modifies PPRC membership provision to indicate that the professions listed for membership are illustrative.

Section 4006. No provision.

(d) Transition to the RBRVS for Primary Care Services.—

Section 12105. Increases the primary care floor to 75 percent for services rendered in 1991. Provides that for the purpose of determining the fees for primary care services increased under this provision after 1991, the historical payment basis will be determined without regard to the increase to 75 percent in the primary care floor. However, the fees for services whose payments are increased under this provision in 1991 may not be lower in 1992 than they were in 1991 after the increase in the floor.

Section 4006. Similar provision.

Effective date:

Section 12105. Effective for services provided on or after January 1, 1991, except (c) Enactment.

Section 4006. Applies to services furnished on or after January 1, 1991.

Senate amendment

*(a) Update.—*Specifies that the MEI update that applies April 1, 1991 is equal to the full MEI for primary care services and 0 percent for other services.

Specifies that in determining the customary charges for the period beginning April 1, 1991, the Secretary may not recognize any amounts of 1990 actual charges that exceed the customary charges for the nine month period beginning April 1, 1990. This limitation shall not prevent an increase in the percentage limit applicable to a new physician in a case where such new physician was subject to new physician limits in 1990.

*(b) Physician Medicare Volume Performance Standards.—*Provides that the adjustment factor is minus 1 percent in FY 1991, 1.5 percent in FY 1992, and 2.0 percent for each succeeding fiscal year. Specifies that the MVPS for 1991 is the sum of: (1) the Secretary's estimate of the rate of increase in expenditures for portions of the calendar year occurring in such fiscal year (determined without regard to OBRA 1990); and (2) the Secretary's estimate of the percentage increase or decrease in expenditures in the category of services involved that will result from changes in law or regulations. This sum is reduced by 2 percentage points.

*(c) Revise Authority for PPRC.—*No provision.

*(d) Transition to the RBRVS for Primary Care Services.—*No provision.

Effective date: (a) and (b) Enactment.

Conference agreement

*(a) Update.—*The Conference agreement includes the Senate amendment with an amendment which provides for a reduction of 4/10 of a percentage point in the update for 1992. The Conferees note that the freeze provision does not apply to ambulance services.

*(b) Physician Medicare Volume Performance Standard.—*The Conference agreement includes the Senate amendment with an amendment to assure this provision will not result in a lower or higher update for 1993 than would apply in the absence of this provision.

(c) *Revise Authority for PPRC.*—The Conference agreement includes the House provision with an amendment requiring the PPRC to comment on the President's budget recommendations for physicians services.

(d) *Transition to RBRVS for Primary Care Services.*—The Conference agreement includes the House provision with an amendment which sets the prevailing charge for primary care services at 60 percent. The agreement does not include the hold harmless provision. The provision is implemented in a budget neutral manner.

3. Other Provisions Relating to Payment for Physician Services (Section 12106-12108 and 4007-4012 of House bill; Sections 6116-6120, 6122-6125 of Senate amendment)

Present law

(a) *New Physicians.*—OBRA '87 provided that the customary charge screens of new physicians are set at a level no higher than eighty percent of the prevailing charge, as limited by the MEI, for the first year the physician is practicing in an area. The provision is not applicable to primary care services or services furnished in a rural area designated as a health manpower shortage area.

OBRA '89 provided that in the second year of practice, a new physician's customary charge is limited to 85 percent of the prevailing amount. The limit does not apply to primary care services or to services furnished in a rural health manpower shortage area.

These limits expire on December 31, 1990.

(b) *Payments for Assistants at Surgery.*—Under certain circumstances, physicians are paid for serving as assistants at surgery. Typically, the prevailing charge for acting as an assistant is limited to 20 percent of the prevailing charge for the procedure that applies to the primary surgeon.

Payments for physician assistants serving as assistants at surgery cannot exceed 65 percent of the amount that would otherwise be recognized if performed by a physician serving as an assistant at surgery.

(c) *Interpretation of EKGs.*—Payments are not made for the interpretation of simple diagnostic tests. The payment for the interpretation is presumed to be included in the payment for the hospital or office visit. EKGs are the exception to this rule; separate payments are currently made for interpretation of these tests.

(d) *Payment for Technical Component of Diagnostic Tests.*—Payment for diagnostic tests may be made under Part B on the basis of reasonable charges.

(e) *Reciprocal Billing Arrangements.*—Some carriers have recognized billing arrangements in which a physician occasionally covers for another physician. However, HCFA has considered prohibiting recognition of such arrangements.

(f) *Aggregation Rule.*—Hearings on Part B claims are not available unless the amount in controversy exceeds \$500 and judicial review is not available unless the aggregate amount in controversy exceeds \$1,000.

(g) *Practicing Physicians Advisory Council.*—No provision.

(h) *Medical Review Screens.*—Medical review screens used by carriers are generally not publicized.

(i) *Advance Determinations by Carriers.*—Medicare carriers review Part B claims in order to determine whether the item or service is covered by Medicare and whether or not it is medically necessary. In most cases the review is retrospective.

(j) *Limitation on Beneficiary Liability.*—Current law establishes a limit on actual charges of nonparticipating physicians known as the maximum allowable actual charge. These limits vary from physician to physician based on how much a physician's actual charge for a particular service exceeded Medicare's allowed amount in a base period.

OBRA 1989 established a new physician payment methodology which will be phased-in beginning in 1992. At the same time it established a new method for calculating the limit on actual charges for nonparticipating physicians, beginning in 1991. In 1991, the limit on actual charges for a physician is the same percentage (not to exceed 25 percent) above the 1991 recognized payment amount as his/her 1990 MAAC was above the 1990 recognized payment amount. Because of differing effective dates, total allowed charges for some services for which payments will increase under the new system—primarily evaluation and management services—will be lower in 1991 than in either 1990 or 1992.

(k) *Statewide Fee Schedule Areas.*—The day-to-day functions of reviewing Part B claims and paying benefits are performed by entities known as carriers.

Carriers are responsible for delineating prevailing charge localities. There are 238 prevailing charge localities nationwide; there is considerable variation in the size and configuration of these localities.

Under the physician payment reform provisions, current localities would be used. However, OBRA 1989 required PPRC to report to Congress by July 1, 1991 on the appropriateness of retaining current locality designations, changing to statewide designations, or adopting Metropolitan Statistical Areas or other payment areas for payment purposes.

(l) *Utilization Screens for Physician Visits in Rehabilitation Hospitals.*—OBRA 1987 required the establishment of separate utilization review screens for physician visits in rehabilitation hospitals.

(m) *Study of Payment Adjustment for Physicians Furnishing a High Volume of a Particular Procedure.*—No provision.

House Bill

(a) *New Physicians.*—

Section 12106. Extends the current provision for 1991 to specify that the customary charge limits are 80/85/90/95 percent of the prevailing charge in the first through fourth years of practice. Provides that beginning on January 1, 1992, these percentage limits for new physicians in their first through fourth years of practice apply to the amounts recognized under the RBRVS.

Section 4007. Similar provision except continues under RBRVS the exception for primary care services and services furnished in a rural area defined as a health manpower shortage area. Extends application of the provision to professional services furnished by health care practitioners. A health care practitioner is a physician assistant, certified nurse-midwife, qualified psychologist, nurse

practitioner, clinical social worker, physical therapist, occupational therapist, respiratory therapist, certified registered nurse anesthetist, or any other practitioner specified by the Secretary. The first year of practice is defined as the first year during which Medicare payments are made to the practitioner during the first six months.

Requires the Secretary in computing the conversion factor for 1992, to assume that these changes applied to all physicians services furnished during the year notwithstanding the effective dates.

(b) Payments for Assistant at Surgery Services.—

Section 12107. Requires the Secretary to determine, based on the most recent available data, for each class of surgical procedure, the national average percentage of such procedures performed under Part B which involve the use of an assistant at surgery. Maintains the current policy for a physician acting as an assistant at surgery for a procedure that involves the use of an assistant at least 50 percent of the time. Provides that when an assistant is used in 25 percent or more of such cases but less than 50 percent nationwide, the payment equals 75 percent of the payment basis that would otherwise apply. When an assistant is used in 5 percent or more of such cases but less than 25 percent nationwide, the payment equals 75 percent of the payment basis that would otherwise apply; however, such payments may only be made if the use of an assistant is approved in advance by the peer review organization. Payment may not be made for an assistant at surgery if an assistant is used in fewer than 5 percent of cases.

Section 4007. No provision.

(c) Interpretation of EKGs.—

Section 12108. Provides that payments for the interpretation of EKGs are to be treated in the same manner as the payment for the interpretation of other simple diagnostic tests under RBRVS, effective Jan. 1, 1992. Separate payments would not be made for interpretation of these tests, except when the EKG is not performed in conjunction with an office or hospital visit. Payment would continue to be made for the technical component of EKGs performed on an outpatient basis.

Excludes payments for EKG interpretations performed in conjunction with an office visit, or for inpatients, from the expenditure base used in determining the initial budget neutral conversion factor for the RBRVS.

Section 4007. No provision.

(d) Payment for Technical Component of Diagnostic Tests.—

Section 12108. No provision

Section 4008. Provides that when Part B payments are made for the technical, as distinct from the professional, component of diagnostic tests the reasonable charge (or other payment basis) may not exceed the national median of such charges (or payment basis) for such tests. The provision does not apply to clinical diagnostic laboratory tests and radiology services.

(e) Reciprocal Billing Arrangements.—

Section 12108. No provision.

Section 4009. Provides that payment may be made to a physician who arranges for visit services (including emergency visits and related services) to be provided on an occasional, reciprocal basis by another physician in his or her absence. Such payments may only

be made if: (1) the first physician is unavailable to provide the services; (2) the individual has arranged to receive the services from the first physician; (3) the claim form includes the first physician's identifier number and indicates that it is for a "covered visit service;" and (4) the visit services are not provided by the second physician over a continuous period of longer than 30 days.

(f) Aggregation Rule.—

Section 12108. No provision.

Section 4010. Permits aggregation of claims for services furnished in the same 12-month period. If the claims involve common issues of law and fact relating to physicians services furnished in the same fee schedule area to two or more patients by two or more physicians, the aggregate amount in controversy must exceed \$1,000 for a hearing and \$2,500 for judicial review.

(g) Practicing Physicians Advisory Council.—

Section 12108. No provision.

Section 4011. Establishes a 15-member Practicing Physicians Advisory Council appointed by the Secretary. Members must have submitted at least 250 physicians services claims in the preceding year. At least 11 members must be MDs or DOs. Members are to include both participating and nonparticipating physicians and physicians practicing in rural and underserved areas. The Secretary is to consult with the Council concerning proposed changes in regulations and carrier manual instructions. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes. The Council is to meet at least once each calendar quarter; members are to be paid in the same manner as other advisory council members.

(h) Medical Review Screens.—

Section 12108. No provision.

Section 4012. Requires carriers to release medical review screens and associated screening parameters applicable for determinations of reasonable and necessary, prior to making payment denials for otherwise covered physicians services.

*(i) Advance Determinations by Carriers.—*No provision.

*(j) Limitation on Beneficiary Liability.—*No provision.

*(k) Statewide Fee Schedule Areas.—*No provision.

*(l) Utilization Screens for Physician Visits in Rehabilitation Hospitals.—*No provision.

*(m) Study of Payment Adjustment for Physicians Furnishing a High Volume of a Particular Procedure.—*No provision.

Effective date:

Sections 12106-12108, (a) Provisions concerning the third and fourth year of practice applies to services furnished in 1991 which were first subject to the limits in 1989 or thereafter; provisions relating to RBRVS apply to services furnished after 1991. (b) Applies to services furnished on or after January 1, 1991. (c) Effective January 1, 1992.

Sections 4007-4012. (a) Applies to services furnished after 1990, except that: (1) the provisions concerning the third and fourth year of practice apply only to physicians services furnished after 1991 and 1992; and (2) the provisions concerning the second, third, and fourth year of practice apply only to physicians services furnished after 1991, 1992, and 1993. (d) Applies to tests furnished on or after

January 1, 1991. (e) and (f) Applies to services furnished on or after the first day of the first month beginning more than 60 days after enactment. (g) Enactment (h) Applies to denial notices sent on or after January 1, 1991.

Senate amendment

(a) *New Physicians*.—Extends the current provision to specify that the customary charge limits are 80/85/90/95 percent of the prevailing charge in the first through fourth years of practice. Applies similar treatment to new physicians under RBRVS.

(b) *Payments for Assistant at Surgery Services*.—Specifies that if payment is made separately for a physician serving as an assistant-at-surgery, such payment may not exceed 16 percent of the payment for the global surgical service involved.

(c) *Interpretation of EKGs*.—No provision.

(d) *Payment for Technical Component of Diagnostic Tests*.—No provision.

(e) *Reciprocal Billing Arrangements*.—Provides that payment may be made in the case of services furnished by a physician other than the one submitting the claim either: (1) during a period not exceeding 14 continuous days in the case of an informal reciprocal arrangement; or (b) 90 continuous days (or longer, as specified by the Secretary) in the case of per diem or other fee for time compensation. The claim must identify the physician furnishing the service.

(f) *Aggregation Rule*.—No provision.

(g) *Practicing Physicians Advisory Council*.—No provision.

(h) *Medical Review Screens*.—Requires the Secretary to conduct a study of the effect of the release of prepayment medical review screen parameters on physician billings. The study is to be based on release of the same parameter or parameters at a minimum of six carrier sites. The Secretary is to report to Congress on the study by Oct. 1, 1992.

(i) *Advance Determinations by Carriers*.—Requires the carriers to make advance medical necessity determinations for expensive items and services specified by the Secretary.

Authorizes the carriers to make advance medical necessity determinations if:

The item or service is furnished or ordered by a physician for whom a substantial number of items and services have been disallowed, or for whom a pattern of overutilization has been identified by the carrier and the physician has been so informed and given an opportunity to respond;

The the carrier notifies the physician as to the kinds of items and services that will be subject to advance determinations, and

The carrier provides a general notice for entities likely to furnish the kinds of items or services described in such notice that are ordered by the physician.

Authorizes the carrier to make advance medical necessity determinations if:

The item or service is furnished by an entity for whom a substantial number of items or services have been disallowed, or a pattern of overutilization resulting from the business prac-

tices of the entity has been identified by the carrier and the entity has been so informed and given an opportunity to respond; and

The carrier notifies the entity of the kinds of items that will be subject to advance determinations.

Provides that these provisions do not apply to items and services under review by a PRO, to emergency cases or under such other circumstances as specified by the Secretary.

(j) *Limitation on Beneficiary Liability*.—Provides that the limit in 1991 for evaluation and management services provided by a non-participating physician is the same percentage (not to exceed 50 percent) above the 1991 recognized payment amount as the physician's 1990 MAAC was above the 1990 recognized payment amount.

(k) *Statewide Fee Schedule Areas*.—Requires the Secretary, under certain circumstances, to treat a State as a single fee schedule area for purposes of determining both the adjusted historical payment basis and the fee schedule amount for physicians services furnished on or after January 1, 1992. The State on or before April 1, 1991, must have written support for treatment of the State as a single fee schedule area from each member of its Congressional delegation and from organizations representing urban and rural physicians in the State. The Secretary may provide that its treatment of a State as a single fee schedule area will ensure that total payments for physicians services in 1992 are budget neutral compared to what they would otherwise have been.

Specifies that this provision may not be construed as limiting subsequent modifications to the locality structure through otherwise applicable administrative procedures.

(l) *Utilization Screens for Physician Visits in Rehabilitation Hospitals*.—Requires the Secretary, within 180 days of enactment, to revise the screens to apply to all physician visits to an inpatient of a rehabilitation hospital or unit. The screen is to reflect a standard of physician care recognized for inpatients of acute care hospitals and units, particularly with respect to the frequency of visits by an attending physician. The Secretary is to provide that this provision be implemented in a budget neutral manner.

(m) *Study of Payment Adjustment for Physicians Furnishing a High Volume of a Particular Procedure*.—Requires PPRC to conduct a study of the feasibility and desirability of adjusting payments to individual physicians performing a high volume of a particular procedure in order to reflect economies of scale. Taking into account the potential impact on costs and access the Commission is to report on: (i) types of services or procedures for which such an adjustment would be appropriate; (ii) options for implementing such an adjustment; (iii) appropriate exceptions to such an adjustment; and (iv) appropriate safeguards to ensure access by beneficiaries to necessary services. The Commission is required to report by July 1, 1992 to the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance.

Effective date: (a) Applies to services furnished on or after Jan. 1, 1991. (b) Applies with respect to services furnished on or after January 1, 1991. (c) Applies to services furnished on or after the date of enactment. (d) Becomes effective with respect to items and serv-

ices furnished on or after January 1, 1991. (j), (k), (l) and (m) Enactment.

Conference agreement

(a) *New Physicians.*—The Conference agreement includes Section 4007 of the House provision.

(b) *Assistants at Surgery.*—The Conference agreement includes the Senate amendment with an amendment which precludes payments for assistants at surgery where such assistant is used in less than five percent of the cases.

(c) *Interpretation of EKG's.*—The Conference agreement includes the House provision with a clarification specifying that a routine electrocardiogram interpretation covered by this provision is one specified under one of the following HCPCS codes: 93000, 93010, 93040, 93041, and 93042 (and any changes in these codes that may result). The provision is effective in 1992.

(d) *Payment for Technical Component of Diagnostic Tests.*—The conference agreement includes the House provision. The Conferees note that if a procedure is subject to a limitation under the provision reducing payments for overvalued procedures, it is not subject to the limitations under this provision. Further, if a procedure is subject to a limitation under this provision, it can not be subject to any limitation under the provision reducing payments for unsurveyed procedures.

(e) *Reciprocal Billing Arrangements.*—The Conference agreement includes the House provision with an amendment deleting the mandatory assignment requirement and a modification to change the continuous day limit to 60 days.

(f) *Aggregation Rule.*—The conference agreement includes the House provision with an amendment to provide for a study of the issue of the aggregation of appeals.

(g) *Practicing Physicians Advisory Council.*—The Conference agreement includes the House provision with an amendment to clarify the role of the advisory council.

(h) *Medical Review Screens.*—The conference agreement includes the Senate amendment.

(i) *Advance Determinations by Carriers.*—The conference agreement does not include the Senate amendment.

(j) *Limitation on Beneficiary Liability.*—The Conference agreement includes the Senate amendment with an amendment setting the maximum MAAC at 140 percent of the recognized charge for 1991 for evaluation and management services.

(k) *Statewide Fee Schedule Areas.*—The Conference agreement includes the Senate amendment with an amendment specifying that the provision applies to Oklahoma and Nebraska only.

(l) *Utilization Screens for Physician Visits in Rehabilitation Hospitals.*—The Conference agreement includes the Senate amendment with an amendment to require the Secretary to issue guidelines to assure that the level of review required when the new visit screen limit has been reached is to be uniform across localities.

(m) *Study of Payment Adjustments for Physicians Furnishing a High Volume of a Particular Procedure.*—The Conference agreement does not include the provision.

The Conference agreement further requires the Secretary to conduct a study of regional variations in impact of Medicare physician payment reform. The study is to examine factors contributing to variations in reasonable charges which are not attributable to variations in practice costs; the impact on access to services in areas that experience disproportionately large payment reductions under the fee schedule; and appropriate adjustments or modifications in the transition to or determining payments under the fee schedule.

4. Payments for Hospital Outpatient Services (Sections 12111 and 4021 of the House Bill and Section 6130 of the Senate amendment)

Present law

(a) *Capital.*—For hospital outpatient department services which are paid either on a reasonable cost basis or the lesser of reasonable costs and a blend of reasonable costs and charges, Medicare paid for hospital capital allocated to the outpatient department of the hospital at 100 percent of costs prior to fiscal year 1990.

OBRA '89 reduced payments for capital costs for outpatient services by 15 percent for portions of cost reporting periods beginning in fiscal year 1990. The reduction also applied to capital related to services that are reimbursed based on a blended amount; these services include radiology, diagnostic procedures and outpatient surgery. In the case of such blends or limits based on blends, the reduction applied only to the cost portion of the blended amount.

Outpatient capital costs of sole community hospitals were exempt from the reduction in OBRA '89.

(b) *Outpatient Services on a Cost Related Basis.*—Services in hospital outpatient departments are reimbursed under a variety of payment methodologies. Laboratory services and durable medical equipment are paid based on fee schedules; outpatient dialysis services are paid based on a prospective rate; and ambulatory surgical services and radiology services are subject to aggregate cost limits. Most other services are paid on a cost related basis.

(c) *Development of Prospective Payment Proposal.*—No provision.

(d) *Ambulatory Surgery in Eye, and Eye and Ear Specialty Hospitals.*—Payments to an eye, or eye and ear specialty hospital for ambulatory surgery that makes application to the Secretary in which it demonstrates: (1) that it received more than 30 percent of its total revenue from outpatient services; and (2) was an eye specialty hospital or an eye and ear specialty hospital on October 1, 1987 are made on the basis of a blend that consists of 75 percent of the hospital's costs and 25 percent of the applicable free-standing ambulatory surgical center rate. This blend will change to the 50/50 blend that applies to ambulatory surgery in all other hospitals for cost reporting periods that begin after fiscal year 1990.

(e) *Payments for Ambulatory Surgery and Radiology.*—Reimbursement for ambulatory surgery services performed in outpatient hospital departments are reimbursed the lesser of: (1) reasonable costs or customary charges, less 20 percent of hospitals' reasonable

charges, but not exceeding 80 percent of reasonable costs; or (2) the "blend" amount, which averages reasonable cost principles with free standing ambulatory surgery payment rates. The mix of the blend is 50 percent reasonable costs and 50 percent of the rate paid to free standing ambulatory surgery centers. Payments for outpatient radiology services are subject to an aggregate limit for each hospital. The limit applies to both capital and non-capital costs and is the lesser of the reasonable costs or charges or a blend of hospitals' cost for providing these services and the prevailing charges for providing the same services in physicians' offices. The blend is based on 50 percent costs and 50 percent charges. Payment for intraocular lenses inserted at an ambulatory surgery center during or subsequent to cataract surgery is made on the basis of reasonable costs for class of lens involved.

House bill

(a) *Capital*.—Section 12111. The 15 percent reduction applied to capital costs for outpatient hospital services and the cost portion of outpatient hospital services paid on the basis of a blended amount by OBRA '89 for cost reporting years during the period beginning on October 1, 1989 and ending December 31, 1993 with one modification. In addition to sole community hospitals, rural primary care hospitals would also be exempt from the reduction.

Section 4021. Reduces payments for capital costs paid on a cost basis by 10 percent for cost reporting periods occurring during fiscal years 1991 or 1992, by 7.5 percent for payments attributable to portions of cost-reporting periods occurring during fiscal year 1993 or 1994, and by 5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1995. Sole community hospitals are exempt from the reduction.

(b) *Outpatient Services on a Cost Related Basis*.—Section 12111. Payments for services that are made on a cost related basis would be reimbursed at 98 percent of the recognized costs for payments attributable to cost reporting periods during the period beginning October 1, 1990 and ending December 31, 1993. This reduction would also apply to the cost portions of blended payment limits for ambulatory surgery and radiology services. Sole community hospitals and rural primary care hospitals would be exempt from this reduction.

Section 4021. Payments for hospital outpatient services reimbursed on a cost basis, other than payment for capital-related costs, would be paid at 95 percent of reasonable costs for cost reporting periods beginning on or after October 1, 1990. Outpatient services performed in hospitals receiving Medicare disproportionate share payments would be exempt from the reduction.

(c) *Development of Prospective Payment Proposal*.—Section 12111. Directs the Secretary to develop a proposal to replace the current payment system for hospital outpatient services with a prospective payment system. In developing this proposal, the Secretary must consider: (1) policies which provide for appropriate limits on growth in expenditures; (2) adjustments to account for changes in types of patients treated, volume, technology, and standards of medical practice; (3) incentives for hospitals to control costs of outpatient services; (4) appropriate bundling of services, such as global fees or

per episode units of payment; (5) whether services not currently paid on a cost related basis, such as outpatient dialysis and laboratory services, should be included in the new system; and (6) whether other adjustments would be necessary, including adjustments for teaching status, geographic areas with high wages, treatment of low-income patients, and capital.

The Administrator of the Health Care Financing Administration would be required to provide summaries of existing research findings on prospective payment for hospital outpatient services by January 1, 1991. This report would be submitted to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives. The Secretary would be required to submit a detailed proposal on prospective payment to the same committees by September 1, 1991. The Prospective Payment Assessment Commission would be required to submit an analysis and comments on the Secretary's proposal to the same committees by March 1, 1992.

Section 4021. No provision.

(d) Ambulatory Surgery in Eye, and Eye and Ear Specialty Hospitals.—Section 12111. The use of the special 75/25 blend would be extended to services provided in cost reporting periods beginning on or after October 1, 1988 and on or before January 1, 1995.

Section 4021. No provision.

(e) Payments for Ambulatory Surgery and Radiology.—Section 12111. Continues the use of the 50/50 blend for cost reporting periods beginning on or after October 1, 1988 and on or before December 31, 1990. For cost reporting periods beginning on or after January 1, 1991, payment for ambulatory surgery services and radiology services performed in outpatient hospital departments would be subject to aggregate cost limits based on a blend of 33 percent of the hospital's own costs and 67 percent of the amount that would be paid if provided in an ambulatory surgery center in the same area.

Reduces payment for insertion of an intraocular lens during or subsequent to cataract surgery in an ambulatory surgery center to \$200 for services performed after the date of enactment and before December 31, 1992.

Section 4021. Reduces payment to hospitals for outpatient surgical procedures by reducing the standard overhead amount used in calculating the amount paid to ambulatory surgery centers for services from 100 percent of the standard overhead amount to 97.5 percent of the standard overhead amount. Exempts hospitals receiving Medicare disproportionate share payment adjustments from the reduction. Reduces payment for insertion of an intraocular lens during or subsequent to cataract surgery in an ambulatory surgery center to \$200 for services performed on or after January 1, 1991 and before December 31, 1992.

Requires that a survey of actual audited costs incurred by ambulatory surgery centers, based on a representative sample of procedures, be taken not later than July 1, 1992 and every 5 years thereafter. Repeals provision permitting the Secretary to determine the appropriate time to adjust ambulatory surgery center rates and stipulates that, if the Secretary has not updated rates paid to ambulatory surgery centers in a year, the rates will be increased by

the consumer price index for all urban consumers for the 12 month period ending with June of the preceding year. Requires the Secretary to consult with appropriate trade and professional organizations in determining the list of procedures that may be performed at ambulatory surgery centers.

Effective date: Section 12111. Enactment. Section 4021. Provision (a) is effective upon enactment. Provision (b) applies to hospital outpatient services provided on or after January 1, 1991. Provision (e) is effective July 1, 1991.

Senate amendment

(a) *Section 6130.*—Reduces payments for capital-related costs for cost reporting periods occurring during the period beginning on October 1, 1989 and ending on September 30, 1991 by 15 percent. Reduces payments for capital-related costs for cost reporting periods occurring during the period beginning on October 1, 1991 and ending September 30, 1995 by 10 percent. Exempts sole community hospitals from the reduction.

(b) *Section 6131.*—Payments for outpatient hospital services that are made on a cost related basis would be reimbursed at 95 percent of the recognized costs for payments attributable to portions of cost reporting periods during the period beginning on October 1, 1990 and ending on December 31, 1995. This reduction would also apply to the cost portions of blended payment limits for ambulatory surgery and radiology services. Sole community hospitals would be exempt from this reduction.

(c) *Section 6130.*—No provision.

(d) *Section 6131.*—Extends the use of the 75/25 blend to services provided in cost reporting periods beginning on or after October 1, 1988 and before September 30, 1993.

(e) *Payments for Ambulatory Surgery and Radiology.*—Section 6131. No provision.

Effective date: Enactment.

Conference agreement

OUTPATIENT SERVICES

(a) *Capital.*—The conference agreement includes the House bill with an amendment. Capital costs for outpatient hospital services and the cost portion of outpatient hospital services paid on the basis of a blended amount for payments attributable to portions of cost reporting periods occurring during FY 91 would be reduced by 15 percent. Such payments would be reduced by 10 percent for portions of cost reporting periods occurring during FY 92, 93, 94 and 95. Sole community hospitals and primary care hospitals would be exempt from these reductions.

(b) *Outpatient Services on a Cost-Related Basis.*—The conference agreement includes the Senate amendment with an amendment. Payments for outpatient hospital services made on a reasonable cost basis would be reduced by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, 1992, 1993, 1994, or 1995.

(c) *Prospective Payment System for Hospital Outpatient Services.*—The conference agreement includes the House bill.

(d) *Ambulatory Surgery in Eye, and Eye and Ear Specialty Hospitals.*—The conference agreement includes the House provision.

(e) *Amubulatory Surgery and Radiology.*—The conference agreement includes the House bill with an amendment. For portions of cost reporting periods beginning on or after January 1, 1991, payment for ambulatory surgery services and radiology services performed in outpatient hospital departments would be subject to aggregate cost limits based on a blend of 42 percent of the hospital's costs and 58 percent of the fees for the same services performed outside the hospital.

5. *Durable Medical Equipment (Sections 12112 and 4022 of House bill and Sections 6132 and 6133 of Senate Amendment)*

Present law

(a) *Overvalued Equipment.*—OBRA 1989 reduced the fee schedule amounts for seatlift chairs and transcutaneous electrical nerve stimulation (TENS) devices by fifteen percent, effective April 1, 1990.

(b) *Limits on Variations in Fees.*—Current law provides for transition to a system of regional fees for three categories of DME by 1993. The categories are orthotics and prosthetics, rental-cap items, and oxygen and oxygen equipment. The regional fees would be based on a weighted average of local and regional payment amounts within each region, subject to certain upper and lower limits. Payments in 1990 are based solely on the local amounts; payments in 1993 would be based solely on the regional amounts. 1991 and 1992 would be transition years between the two amounts.

(c) *Rental Cap Items.*—OBRA '87 defined six categories of DME and established fee schedules for each category. Payment for items in the category of "other items of DME," often referred to as the "rental cap" category, is only on a rental basis. Items in this category include wheel chairs and hospital beds. The rental payment amount in 1989 and 1990 is ten percent of the purchase price of the item based on average submitted charges during a twelve month base period ending June 30, 1987, and updated by the percent increase in the Consumer Price Index (CPI-U) for the six month period ending December, 1987. Rental payments are made for up to fifteen months, after which a payment, equal to one month's rental, is made every six months for servicing.

OBRA '89 removed motorized wheelchairs from the "rental cap" category into the "frequently purchased" category with a provision allowing for treatment of such wheelchairs as customized equipment, subject to guidelines to be established by the Secretary.

(d) *Frequently Serviced Items.*—Items in the category known as "frequently serviced" are reimbursed on a rental basis. These items are defined as equipment which requires frequent servicing to avoid danger to the patient and includes such items as ventilators, intermittent positive pressure breathing machines and vaporizers. Rental payments for these items are based on average allowed charges for the items during a base period, updated by the percentage change in the CPI-U. There is no limit on the number of months that rental payments are made for "frequently serviced" items.

(e) *Useful Lifetime of Rental Equipment.*—There is currently no provision for replacement and for a new cycle of rental payments for items provided under the rental cap category.

(f) *Enteral and Parenteral Equipment and Supplies.*—Nutritional supplies for enteral equipment are reimbursed on a reasonable charge basis. The payment amounts for these services are updated by the CPI-U.

(g) *Administrative Procedures.*—The Secretary may require medical equipment suppliers to have a written order for an item from a physician prior to delivery of certain items.

(h) *Orthotics and Prosthetics.*—Orthotics and prosthetics are included in the covered items other than durable medical equipment category of DME. Payment for this category of equipment is made on a lump sum basis for purchase. Two elements for the basis of the payment for purchase of the equipment. The first is the base local purchase price, which is defined as the average reasonable charge in the locality for the purchase of the item for the 12 month period ending with June, 1987, updated by the consumer price index for all urban consumers for the six month period ending with December, 1987.

The second component consists of the regional purchase price, which is equal to the weighted averages of purchase prices in the region. Payment is made solely on the basis of local purchase prices in 1990. In 1991, payment is the sum of 75 percent of the local purchase price and 25 percent of the regional purchase price. In 1992, payment is equal to 50 percent of the local purchase price and 50 percent of the regional purchase price. In 1993 and subsequent years, payment is made solely on the basis of regional purchase prices. In 1991, the range of the recognized payment may not exceed 125 percent, or be lower than 85 percent of the average of the purchase prices recognized for all the carrier service areas in the U.S. In subsequent years, the range of the recognized payment amount may not be 120 percent or be lower than 90 percent of the average of the purchase prices recognized for all carrier service areas in the country.

(i) *Oxygen and Oxygen Equipment.*—No provision.

House bill

(a) *Overvalued Equipment.*—Section 12112. The fee schedule amounts for seatlift chairs and TENS devices would be reduced by fifteen percent.

Section 4022. Similar provision.

(b) *Limits on Variations in Fees.*—

Section 12112. The requirements relating to regional fees would be repealed, except for orthotics and prosthetics as described below. National upper and lower fee limits would be established for the following categories of DME: (1) inexpensive and routinely purchased DME; (2) items requiring frequent and substantial servicing; (3) miscellaneous items and other covered items; and (4) oxygen and oxygen equipment. Local fees above or below these limits would be phased to the national limiting amount in 1993.

National fee upper limits for an item would be defined as the median of the fees that apply in 1990. The upper limits would be updated annually. In 1991 and 1992, payments would be capped by

a weighted average of the local fee schedule amount and the national limit. In 1991, the average would be based on 67 percent of the local fee and 33 percent of the national limit. In 1992, the average would be based on 33 percent of the local fee and 67 percent of the national limit. In 1993, the fee schedule amounts in areas that exceed the upper limit would be set at the national limit.

National fee "floors" for an item would be defined as 85 percent of the median of the fees that apply in 1990. The fee floors would be updated annually. In 1991 and 1992, payments would be subject to a lower limit equal to a weighted average of the local fee schedule amount and the national floors. In 1991, the average would be based on 67 percent of the local fee and 33 percent of the national floor. In 1992, the average would be based on 33 percent of the local fee and 67 percent of the national floor. In 1993, the fee schedule amounts in areas that are below the national floor would be set at the floor.

Fees in areas that are between the median and 85 percent of the median would not be affected by this provision.

Section 4022. Identical provision.

(c) *Rental Cap Items.*—Section 12112. The fee schedules for rental cap items would be based on average allowed charges, rather than average submitted charges.

Rental payments for "rental cap" items would be based on ten percent of the average allowed purchase price during the base period for the first three months of rental, and 7.5 percent of the average allowed purchase price during the fourth through fifteenth months of rental. Total rental payments would equal 120 percent of the average allowed purchase price. No rental payments would be made after the fifteenth month.

In the tenth month of continuous rental, patients would be given the option to purchase the item of equipment. If the patient elects this option, rental payments would continue through the thirteenth month of rental when ownership of the item would transfer to the patient. No additional rental payments would be made. For items owned by patients, payments for maintenance and servicing would be determined by the Secretary to be appropriate for the particular type of equipment and would be based on reasonable charges. If the patient declines the purchase option, payments for the equipment and servicing would be the same as provided under current law.

Non-customized motorized wheelchairs would be returned to the category of other covered items of DME (the rental cap category). The Secretary would be authorized to treat customized wheelchairs under the payment provisions for the customized items category of DME.

Section 4022. Similar provision, except that payment would continue to be made on the basis of average submitted charges.

(d) *Frequently Serviced Items.*—Section 12112. Rental payments for items in the category known as "frequently serviced" would be limited to fifteen months. After the succeeding six month period, the Secretary would make payments for servicing every six months. The servicing payment could not exceed 200 percent of a monthly rental fee and would include payment for parts and labor not covered by warranty. The Secretary would be authorized to

make payments for necessary disposable supplies used in conjunction with the item. If the reasonable lifetime of the item is reached during a period of continuous use or if the Secretary determines, based on a carrier's investigation, that an item is lost or irretrievably damaged, monthly rental payments may be made for the replacement item on the same basis as the original item.

Section 4022. Identical provision.

(e) *Useful Lifetime of Rental Equipment.*—Section 12112. The Secretary would establish a reasonable useful lifetime for two categories of equipment: (1) miscellaneous items and devices; and (2) items requiring frequent and substantial servicing. The useful lifetime would be 5 years, unless the Secretary finds, based on program experience, that a longer or shorter period is appropriate for an item. After an item's useful lifetime is reached during a period of medical necessity, the Secretary would provide for a new cycle of rental payments.

Carriers would be permitted to make exceptions, and begin a new cycle of rental payments, for equipment that is lost or irreparably damaged.

Section 4022. Similar provision, except that the useful lifetime is not deemed to be 5 years, unless the Secretary finds otherwise.

(f) *Enteral and Parenteral Equipment and Supplies.*—Section 12112. No update of fees for enteral and parenteral equipment and supplies would be authorized for 1991.

Section 4022. Identical provision.

(g) *Administrative Procedures.*—Section 12112. Suppliers would be prohibited from distributing completed or partially completed Medicare medical necessity forms to patients for commercial purposes. Suppliers who knowingly and willfully distribute such forms would be subject to civil monetary penalties of up to \$1,000 per form distributed.

For customized equipment and for equipment designated by the Secretary as requiring a prior written physician's order, suppliers could request prior approval of the item from a carrier in a form determined by the Secretary.

The Secretary would establish standards for the timeliness of carrier responses to such requests, and would incorporate such standards into the evaluations of carriers' performance.

Claims for items of DME that are potentially overused would be subject to special carrier scrutiny. The Secretary would publish, and periodically update, a list of such items. The list would include: seatlift chairs, transcutaneous electrical nerve stimulators, power-driven scooters, and such other items of DME as determined appropriate by the Secretary. The Secretary would include items that are: (1) mass marketed directly to beneficiaries; (2) marketed with offers to waive the coinsurance, or marketed as "free" or "at no cost" to beneficiaries with Medigap coverage or other coverage; (3) subject to a consistent pattern of overutilization; and (4) frequently denied based on a lack of medical necessity.

Section 4022. Similar provision.

(h) *Orthotics and Prosthetics.*—Section 12112. Payments for orthotics and prosthetics would continue to be made on the same basis as in current law, but under a new section of law. The transition to payment based solely on regional purchase prices would be delayed

by one year, to 1994 and the transition schedule to a regional basis would be revised. In 1991, payment would be made solely on the basis of local purchase prices. In 1992, payment would be based on the sum of 75 percent of the local purchase price and 25 percent of the regional purchase price. In 1990, payment would be the sum of 50 percent of the local purchase price and 50 percent of the regional purchase price.

No update for orthotic and prosthetic fees would be permitted in 1991. Directs the General Accounting Office to conduct a study of payments for prosthetic devices, orthotics and prosthetics under Medicare to examine the effect of the development and implementation of the Medicare fee schedules on payments for such items to orthotists and prosthetists. The report is due to the House Committees on Ways and Means and the Energy and Commerce and the Senate Finance Committee, including recommendations that the Comptroller General considers appropriate.

Section 4022. The Secretary would be required to conduct a study of the feasibility and desirability of establishing a separate fee schedule for suppliers of prosthetics, orthotics and prosthetic devices who provided professional medical services that would take into account the providers' costs in providing these services. The Secretary's report would be due to Congress one year after enactment.

(i) *Oxygen and Oxygen Equipment.*—Section 12112. Prohibits payment for home oxygen therapy services after the expiration of a three month period that begins on the date a patient first receives such services unless, in accordance with criteria developed by the Secretary in consultation with suppliers, the patient's attending physician certifies that, based on a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 15 days of the three month period, there is a continued medical need for the services. Directs the Secretary to permit home oxygen therapy suppliers to manage the follow-up testing process.

Section 4022. Stipulates that a patient receiving home oxygen therapy services, who at the time such services are initiated, have initial arterial blood gas values at or above a partial pressure of 50 or an arterial oxygen saturation at or above 85, will not receive services after a sixty days period has expired unless the patient's attending physician certifies a continuing medical need for the service. The physician's certification is to be based on a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 15 days of each 60 day period.

Effective date:

Section 12112. Effective for services provided on or after January 1, 1991, except for the following provisions: (1) the provision in item (g) requiring contracts with carriers to meet timeliness standards, which applies to contracts entered into on or after January 1, 1991. Provision (i) applies to patients who first receive home oxygen therapy services on or after January 1, 1991.

Section 4022 is effective for services provided on or after January 1, 1991, except as follow: (1) The provision prohibiting suppliers from distributing medical necessity forms applies to forms or docu-

ments distributed on or after January 1, 1991; (2) the provision regarding home oxygen services applies to items furnished on or after January 1, 1994, applies to patients who first receive home oxygen therapy services on or after January 1, 1991; and (3) a technical correction specifying that the provisions of OBRA '87 also applied to oxygen and oxygen equipment takes effect as if included in OBRA '87.

Senate amendment

(a) *Overvalued Equipment.*—No provision.

(b) *Limits on Variations in Fees.*—Section 6132. The requirements relating to regional fees would be repealed, except for orthotics and prosthetics. National upper and lower fee limits would be established for the following categories of DME: (1) inexpensive and routinely purchased DME; (2) items requiring frequent and substantial servicing; (3) miscellaneous items and other covered items; and (4) oxygen and oxygen equipment. Local fees above or below these limits would be phased to the national limiting amount in 1992.

National fee upper limits for an item would be defined as the median of the fees that apply in 1990. The upper limits would be updated annually by the covered item increase for that year. In 1991, payments would be capped by a weighted average of the local fee schedule amount and the national limit. In 1992 and subsequent years, the limit would be equal to the previous year's limit updated by the covered item increase for that year.

National fee "floors" for an item would be defined as 85 percent of the median of the fees that apply in 1990. The fee floors would be updated annually. In 1991 and 1992, payments would be subject to a lower limit equal to a weighted average of the local fee schedule amount and the national floors. In 1991, the average would be based on 67 percent of the local fee and 33 percent of the national floor. In 1992, the average would be based on 33 percent of the local fee and 67 percent of the national floor. In 1993, the fee schedule amounts in areas that are below the national floor would be set at the floor.

Fees in areas that are between the median and 85 percent of the median would not be affected by this provision.

(c) *Rental Cap Items.*—Section 6132. The fee schedules for rental cap items would be based on 110 percent of average allowed charges, rather than average submitted charges. Rental payments for "rental cap" items would be based on ten percent of the average allowed purchase price during the base period for the first three months of rental, and 7.5 percent of the average allowed purchase price during the fourth through fifteenth months of rental.

Total rental payments would equal 120 percent of the average allowed purchase price.

(d) *Frequently Serviced Items.*—No provision.

(e) *Useful Lifetime of Rental Equipment.*—No provision.

(f) *Enteral and Parenteral Equipment and Supplies.*—Section 6132. Identical provision to Section 12112.

(g) *Administrative Procedures.*—No provision.

(h) *Orthotics and Prosthetics.*—Section 6133. Identical provision to Section 12112.

(i) *Oxygen and Oxygen Equipment.*—Section 6132. Stipulates that a patient receiving home oxygen therapy services, who at the time such services are initiated, have initial arterial blood gas values at or above a partial pressure of 55 or an arterial oxygen saturation at or above 89, or such other values or saturations as the Secretary may specify, will not receive services after a sixty day period has expired unless the patient's attending physician certifies a continuing medical need for the service. The physician's certification is to be based on a follow-up test of the patient's arterial blood gas value or arterial oxygen saturation conducted during the final 15 days of each 60 day period.

Effective date: Section 6132. Effective for items or services furnished on or after January 1, 1991, except for provision (1), which is effective for patients who first receive home oxygen therapy services on or after January 1, 1991.

Section 6133. Effective for prosthetic devices orthotics and prosthetics furnished on or after January 1, 1991.

Durable Medical Equipment

Conference agreement

(a) *Overvalued Equipment.*—The conference agreement includes the House provision with an amendment. Payment for seatlift chairs would be limited to payment for the seatlift mechanism only. The fee schedule payment amounts for transcutaneous electrical nerve stimulators would be reduced by 15 percent.

(b) *Limits on Variations in Fees.*—The conference agreement contains the House provision contained in Section 4022 with an amendment that reduce the update by 1 percent in 1991 and 1992.

(c) *Rental Cap Items.*—The conference agreement includes the House bill. Suppliers providing power driven wheelchairs would be required to offer individuals an option to purchase the item; payment would be made on a lump-sum basis if the individual elects to purchase the item.

(d) *Frequently Serviced Items.*—The conference agreement includes the House bill with an amendment that permits the Secretary to replace an item under specified conditions.

(e) *Useful Lifetime of Rental Equipment.*—The conference agreement includes the House bill contained in Section 4022.

(f) *Enteral and Parenteral Equipment and Supplies.*—The conference agreement includes the House bill.

(g) *Administrative Procedures.*—The conference agreement includes the House bill contained in Section 12112 with modifications.

(h) *Orthotics and Prosthetics.*—The conference agreement includes the House provision.

(i) *Oxygen and Oxygen Equipment.*—The conference agreement includes the House bill contained in Section 4022 with modifications.

6. Clinical Laboratory Services (Section 12113 and 4023 of House bill; Section 6131 of Senate amendment.)

Present Law

(a) *Laboratory Fee Schedule Update.*—The laboratory fee schedules are generally updated each January 1 by the annual percentage change in the CPI-U over the preceding year.

(b) *National Cap on Laboratory Fee Schedules.*—The local laboratory fee schedules are subject to national ceilings. These ceilings are based on the median of all carrier-wide fee schedules established for that test in that laboratory setting. OBRA '89 reduced the cap from 100 to 93 percent of the national median.

(c) *Clarification of Assignment Rule for Laboratory Tests.*—In general, clinical laboratory tests are only reimbursed on an assigned basis. Since 1988, physicians have been prohibited from billing patients for such tests on an unassigned basis. A recent decision in the U.S. 6th Circuit Court of Appeals indicated that there may be some ambiguity as to whether the assignment requirement applies to such tests performed in all physician offices.

House Bill

(a) *Laboratory Fee Schedule Update.*—

Section 12113. Provides that the annual update in the laboratory fee schedule is reduced by 2 percent in 1991, 1992, and 1993.

Section 4023. No provision

(b) *National Cap on Laboratory Fee Schedules.*—

Section 12113. Reduces the national cap to 88 percent of the median, effective January 1, 1991.

Section 4023. Similar provision except reduction is to 85 percent of the median.

Removes requirement for report on national fee schedule and makes other technical corrections.

(c) *Clarification of Assignment Rule for Laboratory Tests.*—

Section 12113. Clarifies current statutory language to provide that all clinical laboratory tests provided in all settings (except by a rural health clinic) may only be billed on an assigned basis. This includes tests provided in physicians offices.

Section 4023. Similar provision. The definition of referring laboratory is clarified, effective May 1, 1990.

Effective date.

Section 12113. Enactment.

Section 4023. (b) Applies to tests furnished on or after January 1, 1991. (c) Applies as if included in the enactment of OBRA 1989.

Senate Amendment

(a) *Laboratory Fee Schedule Update.*—Provides that the annual update is 2 percent in 1991.

(b) *National Cap on Laboratory Fee Schedules.*—Reduces the national cap to 90 percent of the median, effective January 1, 1991.

(c) *Clarification of Assignment Rule for Laboratory Tests.*—No provision.

Effective date. Enactment.

*Conference agreement**Clinical Laboratory Services**(a) Laboratory Fee Schedule Update.—*

The Conference agreement includes the House provision with an amendment. The update is set at 2 percent for 1991, 1992, and 1993.

*(b) National Cap on Laboratory Fee Schedules.—*The Conference agreement includes Section 12113.

*(c) Clarification of Assignment Rule for Laboratory Tests.—*The Conference agreement includes Section 12113 of the House bill.

The Conference agreement includes Section 4023 of the House bill clarifying the definition of referring laboratory with a clarification. In calculating whether a laboratory bills for more than thirty percent of clinical diagnostic tests performed by another laboratory, referrals to wholly-owned subsidiaries are not counted.

*7. Reduction of Payments under Part B Through December 31, 1990
(Section 12114 of the House Bill)*

Present law

Under the Balanced Budget and Emergency Deficit Control Act of 1985, Medicare benefit payments may be reduced by a sequester of up to 2 percent pursuant to a sequester order by the President if deficit targets for the year are not met. The actual reduction applies to payments for services rendered on or after October 15 of a fiscal year. In order to obtain a 2 percent savings from the entire fiscal year, the actual reduction is 2.034 percent to account for services provided between October 1 and October 15.

Such an order was issued by the President with respect to fiscal year 1990 on October 15, 1989. OBRA '89 directed this sequester order to remain in effect for services under Part B until April 1, 1990. In addition, OBRA '89 provided for a sequester of 1.4 percent that applies to services provided during the last six months of fiscal year 1990.

If payments are reduced under a sequester, patient liability for deductible and coinsurance amounts are unchanged. Patient liability for balance bills may rise under a sequester if a physician's actual charge for a service is not at the maximum allowable actual charge (MAAC).

House bill

Section 12114. Payments to physicians, providers and suppliers under Part B would be reduced by 2 percent for the two month period beginning November 1, 1990. Patient liability for deductibles and coinsurance amounts would remain unchanged for claims billed on an assigned basis. No changes would be made in the computation of the average adjusted per capita cost (AAPC) for health maintenance organization (HMO) contracts or competitive medical plan (CMP) contracts to reflect the reduction.

Section E+C. No provision.

Effective date.—Applies to services provided on or after October 15, 1990 and prior to January 1, 1991.

Senate amendment

No provision.

Effective date. No provision.

MEDICARE PART B

7. Reduction of Payments under Part B

Conference agreement

The conference agreement includes the House bill with modifications. Payments would be reduced by 2 percent for payments made during the period beginning November 1, 1990 and ending December 31, 1990.

8. *Miscellaneous and Technical Amendments (Sections 4024-4027, 4031 of House bill, Sections 6133(c) 6140-6146 of Senate amendment)*

Present law

(a) *Extension of Alzheimer's Disease Demonstrations.*—In OBRA '86, Congress authorized \$40 million for the conduct of up to 10 Alzheimer's disease demonstration projects. Each project provides comprehensive services to Medicare beneficiaries who are enrolled in the Alzheimer's disease demonstrations. The demonstrations were authorized for 3 years.

(b) *Cataract Surgery Demonstration Project.*—The Health Care Financing Administration is developing a pilot demonstration project to test the feasibility of developing an alternate pricing strategy for cataract surgery.

(c) *Coverage of Nurse Practitioners and Clinical Nurse Specialists.*—Under current law, the services of nurse practitioners are covered in specified circumstances, as follows: (1) the services must be those which would be covered if they were performed by physicians; (2) nurse practitioners must be working in collaboration with a physician; (3) services are covered only if they are performed in a skilled nursing facility or nursing facility; and (4) the nurse practitioner must practice within the scope of a State license where the services are performed. Reimbursement is made only on an assigned basis and may be made only to the employer of the nurse practitioner.

In the case of nurse practitioners serving as assistants at surgery, the payment amount is equal to 65 percent of the prevailing charge that would be recognized if performed by nonspecialist physicians. In the case of services performed in a hospital, the payment amount is equal to 75 percent of the prevailing charge that would be recognized for nonspecialist physicians. In the case of all other services, the payment amount is equal to 85 percent of the prevailing charge rate that would be recognized for nonspecialist physicians. Services of clinical nurse specialists are covered as incident to physicians' services if they would be covered if provided by a physician.

(d) *Eyeglass Coverage Following Cataract Surgery.*—Current law prohibits coverage of eyeglasses for refractive purposes. As a matter of policy, the Health Care Financing Administration considers intraocular lenses inserted during or after cataract surgery and

eyeglasses prescribed following cataract surgery to be prosthetic devices. As such, Medicare reimbursement is made for both.

(e) *Coverage of Injectable Drugs for Treating Osteoporosis.*—No provision.

(f) *Medicare Carrier Notice to State Medical Boards.*—Current law requires that if a Medicare carrier makes determinations or payments with respect to physicians' services, that the carrier implement specified programs.

(g) *Partial Hospitalization Services.*—Partial hospitalization services include the following services: (1) individual and group therapy with physicians, psychologists or other mental health professionals practicing within the scope of their State licenses; (2) occupational therapy requiring the skills of a qualified occupational therapist; (3) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; (4) drugs and biologicals furnished for therapeutic purposes (which can not be self administered); (5) individualized activity therapies; (6) family counseling designed to treat the patient's condition; (7) patient training and education; (8) diagnostic services; and (9) other items provided by the Secretary. Partial hospitalization services are covered when they are reasonable and necessary for the diagnosis or active treatment of a patient; are reasonably expected to improve or maintain an individual's condition and functional level and prevent a relapse or hospitalization; and furnished under guidelines developed by the Secretary. Services are covered only if the program is hospital-based or hospital affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care. The course of treatment must be prescribed, supervised and reviewed by a physician. Partial hospitalization services provided by community mental health centers or other free-standing institutions are not covered under Medicare.

(h) *Certified Registered Nurse Anesthetists.*—OBRA '86 provided for direct reimbursement for the services of certified registered nurse anesthetists (CRNAs) on an assigned basis for a two year period beginning January 1, 1989. Reimbursement is the lesser of actual charge, the prevailing charge that would have been recognized if the service had been performed by an anesthesiologist, or a fee schedule developed by the Secretary. The fee schedule incorporates base, time, modifier units and conversion factors. Separate conversion factors are used, depending on whether the CRNA is medically directed by a supervising physician or employed by a hospital. The conversion factors also vary by geographic area. The current rules for payment were established under a notice of a proposed rule, published January 26, 1989 and are being implemented through carrier instruction.

Under current law, rural hospitals are permitted to excluded costs for CRNA services from the prospective payment system and be reimbursed for them on a cost basis if they meet specified conditions.

(i) *Payments to Community Health Center and Rural Health Clinics*

(1) *Payments to Community Health Centers.*—Under regulation, Medicare currently makes payment to Federally Qualified Health Centers (FQHC). In general, these centers are health care clinics

receiving grants under sections 329, 330 or 340 of the Public Health Service (PHS) Act, which provides grants to Community Health and Migrant Health Centers, and centers providing health care to the homeless. Centers receiving grants to provide services to the homeless under section 340 of the PHS Act do not qualify as an FQHC unless they are also receiving grants under either section 329 or 330.

Centers receiving PHS grants under these sections are required to charge low-income patients for services on the basis of a sliding fee scale. Medicare currently pays for services on the basis of the lesser of costs or charges, even when the charges have been adjusted under required PHS sliding fee scales for low-income patients.

(2) *GAO Study of Barriers to Hospital Admitting Privileges for Community Health Center Physicians.*—No provision.

(3) *Payments to Rural Health Clinics.*—Rural health clinics applying for participation in Medicare are first certified by a State certifying agency which then forwards its approval to the Secretary for consideration. Services in clinics awaiting final action by the Secretary are covered, but the clinics must hold such claims until after the Secretary issues final approval.

In order to remain certified, rural health clinics must meet certain staffing requirements. Specifically, the clinic must have a nurse practitioner, physician assistant or certified registered nurse midwife available to furnish patient services at least 50 percent of the time the clinic operates.

The Secretary would have 60 days to approve or deny an applicant rural health clinic's certification as a rural health clinic, effective October 1, 1991. The 60 day period would begin on the date the State Agency that surveys the clinics approves the application.

Independent rural health clinics are reimbursed on the basis of an all-inclusive rate based on reasonable costs. In determining reasonable costs, the Secretary has developed productivity standards for staff working in the clinic. The current standards provide for different levels of productivity standards for physicians than for non-physician practitioners.

The Provider Reimbursement Review Board (PRRB) reviews and considers appeals of cost reports for entities defined as providers of services under the Medicare program.

(j) *Coverage of Mental Health Professional Services.*—No provision.

(k) *Technical Corrections Relating To Physician Payment Provisions.*—

(1) *Comparability Adjustments.*—Carriers may reduce payments for services paid on a reasonable charge basis if the carrier's usual payment in its private business is less than what is otherwise payable under Medicare. The Secretary is also permitted to make inherent reasonableness adjustments.

(2) *Periodic Recalculation of GPCI.*—The Secretary is required to review relative value units every five years and make appropriate adjustments. A similar requirement is not included for geographic indices.

(3) *Volume Performance Standard.*—Generally the Congress is expected to establish the volume performance standard. In the ab-

sence of Congressional action, a default standard is used. This standard is the sum of a number of factors.

(4) *Elimination on the Restriction on the Incorporation of Time in Visit Codes.*—Current law provides that the Secretary may include time in the coding of visits and consultations only for services furnished on or after January 1, 1993.

(5) *Treatment of Price Increases in Determining Performance Standards Rates of Increase.*—One factor that is included in the calculation of the default volume performance standard is the Secretary's estimate of the percentage change in physician expenditures in the fiscal year (not attributable to physicians' fees) which will result from changes in law or regulation.

(6) *Miscellaneous Fee Schedule Corrections.*—OBRA 1989 incorporated the physician payment reform requirements in a new section 1848. The requirements for a number of physician payment studies were retained, though some are no longer necessary.

(7) *Minor and Technical Amendments*—No provision.

House bill

(a) *Extension of Alzheimer's Disease Demonstration.*—Section 4124. Requires the Secretary to submit a final report on the Alzheimer's demonstration projects not later than one year after the demonstrations are completed.

Effective date: Enactment.

(b) *Cataract Surgery Demonstration Project.*—Section W+M. No provision.

Section 4026. Prohibits the Secretary from selecting providers to participate in any demonstration project to evaluate the effectiveness of alternative payments for cataract surgery based solely on the number of cataract surgeries performed. Required the Secretary to monitor the quality of services provided under the demonstration and to develop criteria for selecting providers to participate in the demonstration in consultation with physicians specializing in the care and treatment of eye conditions.

Effective date: Section 4026 Enactment.

(c) *Coverage of Nurse Practitioners and Clinical Nurse Specialists.*—Section W+M No provision.

Section 4024. The services of nurse practitioners would be expanded to cover those provided in a rural area, as determined by the Secretary of Health and Human Services for purposes of Medicare hospital reimbursement. The services of clinical nurse specialists would be covered under the following conditions: (1) the services would be covered if provided by a physician; (2) the clinical nurse specialist is practicing in collaboration with a physician; (3) the services are provided in a rural area, as determined by the Secretary for purposes of Medicare hospital reimbursement; and (4) the clinical nurse specialist is practicing within the scope of a state license. For both nurse practitioners and clinical nurse specialists practicing in rural areas, payments may be made only on an assignment related basis. Payment could be made directly to the practitioner or to a hospital, rural primary care hospital, physician, group practice, ambulatory surgery center, or rural health clinic with which the practitioner has an employment or contractual relationship. Hospitals or primary care rural hospitals billing on

behalf of nurse practitioners or clinical nurse specialists would be prohibited from treating any uncollected coinsurance amounts for these services as a bad debt for purposes of Medicare reimbursement. Any person who knowingly or willfully presents an unsigned claim is subject to civil money penalties of up to \$2,000. Proceedings to initiate the imposition of civil money penalties would be conducted in the same manner as those initiated against other providers. The payment amount for services rendered in hospitals would be equal to 75 percent of the prevailing charge recognized for nonspecialist physicians. For all other services, the payment amount would be equal to 85 percent of the prevailing charge recognized for nonspecialist physicians, or the fee paid under the RB RVS fee schedule.

Effective date: Section W+M No provision. Section E+C Effective for services furnished on or after January, 1, 1990.

(d) *Eyeglass Coverage Following Cataract Surgery.*—Section W+M. No provision.

Section 4025. Includes corrective eyeglasses provided with intra-ocular lenses following cataract surgery, but not including replacement for such glasses.

Effective date: Section 4025. Effective for items and services furnished before, on or after the date of enactment.

(e) *Coverage of Injectable Drugs for Treating Osteoporosis.*—Section W+M. No provision.

Section 4027. Adds coverage of an injectable drug approved for the treatment of a bone fracture related to post-menopausal osteoporosis under the following specified conditions: (1) the patient's attending physician certifies that the patient is unable to learn the skills need to self-administer the drug or is otherwise physically or mentally incapable of self-administering the drug; and (2) the patient meets the requirements for Medicare coverage of home health services. Coverage is added for the drug and its administration furnished on or after January 1, 1991 and on or before December 31, 1992.

Directs the Secretary to conduct a study analyzing the effect of covering osteoporosis drugs under Medicare on patient health and the use of inpatient hospital and extended care services. Directs the Secretary to submit a report to Congress and to include recommendations regarding expansion of Medicare coverage to women with post-menopausal osteoporosis.

Effective date: Section W+M. No provision. Section 4027. Enactment.

(f) *Medicare Carrier Notice to State Medical Boards.*—

WM Technicals: No provision

Section 4031.—Requires Medicare carriers to refer cases of physician unethical or unprofessional conduct to the State medical board or boards responsible for the licensing of the physician involved.

Effective date:

WM Technicals: No provision.

Section 4031.—Applies to cases of unethical or unprofessional conduct that a carrier becomes aware of more than 60 days after enactment of this provision.

Requires the Secretary to provide for such modification of carrier contracts as may be necessary to incorporate the additional requirement imposed by this provision on a timely basis.

(g) *Partial Hospitalization Services.*—No provision.

(h) *Certified Registered Nurse Anesthetists.*—No provision.

(i) *Payments to Community Health Center and Rural Health Clinics.*—

(1) *Payments to Community Health Centers.*—No provision.

(2) *GAO Study of Barriers to Hospital Admitting Privileges for Community Health Center Physicians.*—No provision.

(3) *Payments to Rural Health Clinics.*—No provision.

(j) *Coverage of Mental Health Professional Services.*—No provision.

Effective date: No provision.

(k) *Technical Corrections Relating To Physician Payment Provisions.*—

(1) *Comparability Adjustments.*—No provision.

(2) *Periodic Recalculation of GPCI.*—No provision.

(3) *Volume Performance Standard.*—No provision.

(4) *Elimination on the Restriction on the Incorporation of Time in Visit Codes.*—No provision.

(5) *Treatment of Price Increases in Determining Performance Standards Rates of Increase.*—No provision.

(6) *Miscellaneous Fee Schedule Corrections.*—

WM: No provision.

Section 4013. Corrects certain technical and drafting errors in the Physician Payment Reform provisions of OBRA '89. In addition, the requirements for a number of reports are deleted.

Effective date: Enactment.

(l) *Minor and Technical Amendments.*—

Section 4032. Makes miscellaneous technical corrections.

Effective date: Section 4032. Enactment

Senate amendment

(a) *Extension of Alzheimer's Disease Demonstration.*—Section 6141. Extends authorization for the Alzheimer's disease demonstration projects for an additional two years.

Effective date: No provision.

(b) *Cataract Surgery Demonstration Project.*—No provision.

Effective date: No provision.

(c) *Coverage of Nurse Practitioners and Clinical Nurse Specialists.*—Section 6146. Provides for direct reimbursement for services of nurse practitioners and clinical nurse specialists in rural areas for the services that nurse practitioners and clinical nurse specialists are authorized to perform under State law or State regulatory mechanisms. Defines rural area as any area outside a metropolitan statistical area, as defined by the Office of Management and Budget. Defines nurse practitioner or clinical nurse specialist as an individual who: (1) is a registered nurse and is licensed to practice nursing in the State in which the services are performed; and (2) holds a Master's degree in nursing or a related field from an accredited institution; or (3) is certified as a nurse practitioner or clinical nurse specialist by a duly recognized professional nurses' association. Establishes payment for services at an amount equal to

75 percent of the prevailing charge (or Medicare fee schedule payment amount for participating physicians) in the area. Stipulates that payment may only be made on an assignment-related basis. 10/17/90

Effective date: Section 6146. Effective for services furnished on or after January 1, 1991.

(d) *Eyeglass Coverage Following Cataract Surgery.*—Section 6133. Excludes intraocular lenses from the definition of durable medical equipment. Prohibits the Secretary from issuing regulations which changes the coverage of conventional eye wear furnished to individuals who receive an intraocular implant during or following cataract surgery. Excludes routine regulations regarding prosthetic devices or exclusions from coverage from the prohibition. Specifies that one pair of eyeglasses following cataract surgery is a Medicare covered service.

Effective date: Section 6133. Effective for services furnished on or after January 1, 1991.

(e) *Coverage of Injectable Drugs for Treating Osteoporosis.*—No provision.

Effective date: No provision.

(f) *Medicare Carrier Notice to State Medical Boards.*—

No provision.

Effective date: No provision.

(g) *Partial Hospitalization Services.*—Section 6140. Covers partial hospitalization services provided in community mental health centers are covered. Such coverage is limited to community mental health centers that: (1) provide community mental health services required PHS Act; and (2) meet applicable State licensing or certification requirements for community mental health centers.

Effective date: Effective for services provided on or after April 1, 1991.

(h) *Certified Registered Nurse Anesthetists.*—Section 6142. Establishes the conversion factor for non-medically directed CRNAs at \$15.50 for services furnished in 1991; \$15.75 in 1992; \$16.00 in 1993; \$16.25 in 1994; \$16.50 in 1995; and \$16.75 in 1996. For services furnished in calendar years after 1995, the conversion factor will equal the previous year's conversion factor increased by the update determined under the RB RVS fee schedule for physician anesthesia services for that year. In 1991, the payment area to be used for calculating the conversion factor are the localities used for computing payments for physician anesthesia services. After 1991, the payment areas are to be the same as those used under the RB RVS fee schedule.

In 1991, the geographic adjustment factors applied to the conversion factors are the geographic work index value and the geographic practice cost index used for physicians' services for anesthesia services furnished in the locality, with 70 percent of the conversion factor attributable to work and 30 percent attributable to overhead for services. After 1991, the geographic adjustment factors applied to the conversion factors are the same as those used for physicians' services for anesthesia services under the RB RVS fee schedule, with the same percentages attributable to work, practice expenses and malpractice as under the RB RVS fee schedule. For medically-directed CRNAs, the conversion factor will be \$10.50 for services

furnished in 1991; \$10.75 in 1992; \$11.00 in 1993; \$11.25 in 1994; and \$11.50 in 1995, and \$11.70 in 1996. For services furnished after calendar year 1995, the conversion factor will equal the previous year's conversion factor increased by the update determined for physician anesthesia services that year.

The following exceptions are provided: (1) in the case of a conversion factor that is greater than \$16.50 in 1990, the conversion factor for a calendar year after 1990 and before 1996 is equal to the 1990 conversion factor minus the product of multiplying the last digit of the calendar year and 20 percent of the amount by which the 1990 conversion factor exceeds \$16.50; and (2) in the case of a conversion factor that exceeds \$15.49, but is less than \$16.51, the conversion factor for years after 1990 but before 1996 is the greater of the 1990 conversion factor or the actual conversion factor for that year for non-medically directed CRNAs. Conversion factors used to determine CRNA payments can not exceed the conversion factor used to determine the amount paid for physician services for anesthesia service in the area or locality. CRNA services provided in rural hospitals meeting certain requirements and paid on a cost basis, rather than through the prospective payment system for hospitals would continue to be exempt from paying for such services through the prospective payment system. 10/17/90

Effective date: Section 6142. Enactment.

(i) *Payments to Community Health Center and Rural Health Clinics.*—

(1) *Payments to Community Health Centers.*—Includes federally qualified health center services in the list of medical and other health services covered under Medicare Part B. Federally qualified health centers would be defined as: 1) centers receiving grants under any of sections 329, 330 and 340 of the PHS Act; 2) centers receiving payments as an FQHC as of January 1, 1990; and 3) centers that meet all PHS requirements to be eligible to receive such grants, whether or not they actually are receiving funds under these sections. Defines federally qualified health center services as the same services provided by rural health centers eligible to participate in Medicare. Such services must be provided to an outpatient of a federally qualified health center. The Secretary would be required to establish procedures for qualifying non-funded centers as meeting all of the PHS requirements.

Payment for services provided in federally qualified health centers would be on the same basis as reimbursement for rural health center services. Centers paid on a reasonable charge basis on January 1, 1990 could elect to continue receiving payments on that basis. Medicare would pay eighty percent of the all-inclusive rate without regard to the actual charge for the service. Beneficiaries would be exempt from the requirement to pay a Medicare Part B deductible for services rendered in a federally qualified health center. Coinsurance amounts would be equal to the difference between the actual charge for the service and Medicare's payment, but not more than twenty percent of the all-inclusive rate. Federally qualified health centers would be given a safe harbor from criminal or civil violations under Medicare's anti-kickback rules where an center gave a low-income beneficiary, who qualifies for services subsidized under the PHS Act, a partial or full waiver of Medicare

coinsurance amounts based on a PHS mandated sliding fee scale. Federally qualified health centers would have the same PRRB review and appeal rights as other providers under Medicare for low-income patients.

(2) *GAO Study of Barriers to Hospital Admitting Privileges for Community Health Center Physicians.*—The General Accounting Office (GAO) would be required to conduct a study to determine whether physicians practicing in community and migrant health centers are able to obtain admitting privileges at local hospitals. The study is to review: (1) how many physicians practicing in centers are without hospital admitting privileges or have been denied admitting privileges at a local hospital; or (2) the criteria hospitals use in deciding whether to grant admitting privileges and whether these criteria act as significant barriers to health center physicians obtaining hospital privileges. GAO would submit a report on the study to the House Committees on Ways and Means and Energy and Commerce within 18 months of enactment, and would include in the report such recommendation considered appropriate.

(3) *Payments to Rural Health Clinics.*—The Secretary would be required to notify a rural health clinic of approval or disapproval of their certification as a rural health clinic not later than 60 days after the date that the State agency has determined or applied for the facility to be certified as a rural health clinic (whichever is later), if a State agency has determined that the facility is in compliance with Medicare's conditions of participation. The Secretary would be required to waive for a 1-year period the requirements that a rural health clinic employ a physician assistant, nurse practitioner or certified nurse midwife, or that the clinic require such providers to furnish services at least 50 percent of the clinics operating time to any facility that request such a waiver. Facilities demonstrating an inability, despite reasonable efforts, to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 90-day period could obtain a waiver. Prohibits the Secretary from granting a waiver to a facility requesting a waiver within 6 months after the date of expiration of any previous such waiver for the facility. Requires the Secretary to grant a requested waiver within 60 days after the request is received, and the waiver will be deemed granted unless the request is denied within 60 days after the request is received. The Secretary would be required to determine the productivity of physicians, physician assistants, nurse practitioners, and certified nurse-midwives in a rural health clinic by taking into account the combined services of such staff, and not merely the service within each class of practitioner. Rural health clinics would have the same PRRB review and appeal rights as other Medicare providers.

(j) *Coverage of Mental Health Professional Services.*—Section 6140. Adds coverage of qualified mental health professional services. Stipulates that reimbursement is to be 80 percent of the lesser of the actual charge for the services or an amount determined under a fee schedule established by the Secretary. Payment for services may only be made on an assignment-related basis. Qualified mental health professional services are defined as services and supplies furnished as incident to services furnished by a marriage and family therapist, a psychiatric nurse on-site at a

community health care, and such services that are necessarily furnished on-site (other than at an off-site office of such therapists, nurse or counselor) as part of a treatment plan because of the inability of the individual furnished services to travel to the center because of physical or mental impairment, institutionalization, or similar circumstances. Requires the family therapist, psychiatric nurse or clinical mental health counselor to be legally authorized to perform the services under State law or State regulations and the services would otherwise be covered if furnished by a physician or as incident to a physician's services.

Defines a marriage and family therapist as individual who: (1) possesses a minimum of a master's degree in a field related to marriage and family therapy; (2) after obtaining such degree has performed at least 2 years of supervised clinical experience in the field of marriage and family therapy; (3) is licensed or certified by the State in which such services are performed as a marriage and family therapist, married, family and child counselor, or is licensed under a similar professional title; or (4) in the case of an individual in a State in which does not provide for licensing or certification, is eligible for clinical membership in a national professional association that recognized credentials for clinical membership for marriage and family therapists, as determined by the Secretary.

Defines a psychiatric nurse as an individual who: (1) is licensed to practice professional nursing by the State in which the individual practices nursing; (2) performs such psychiatric nursing services as are authorized under the law of the State in which the individual practices psychiatric nursing; (3) possesses a minimum of a master's degree in nursing with a specialization in psychiatric and mental health nursing or a related field; or (4) possesses a minimum of a master's degree in a related field from an accredited educational institutionalization is certified as a psychiatric nurse by a duly recognized national professional nurse organization, as determined by the Secretary, or is eligible to receive such certification. 10/16/90

Effective date: Section S. Applies to services performed on or after January 1, 1991.

(k) Technical Corrections Relating to Physician Payment Provisions.—

*(1) Comparability Adjustments.—*Carriers are prohibited from adjusting fees under the RBRVS. The Secretary may not make inherent reasonableness adjustments under the RBRVS.

*(2) Periodic Recalculation of GPCI.—*Requires the Secretary to recompute periodically the geographic indices to reflect the most recent data.

*(3) Volume Performance Standard.—*Specifies that the default standard is the product of the specified factors.

*(4) Elimination on the Restriction on the Incorporation of Time in Visit Codes.—*Eliminates the restriction on the incorporation of time in visit costs.

*(5) Treatment of Price Increases in Determining Performance Standards Rates of Increase.—*Specifies that this calculation is to include an estimate of changes in law or regulations affecting the percentage increase in physicians fees.

(6) *Miscellaneous Fee Schedule Corrections*.—Similar to EC provision.

Effective date: Enactment

(1) *Minor and Technical Amendments*.—No provision.

Conference agreement

MEDICARE PART B

8. *Miscellaneous and Technical Provisions*

(a) *Alzheimer's Disease Demonstrations*.—The conference agreement includes the Senate amendment with an amendment.

(b) *Prohibition of Competitive Bidding Demonstration for Cataract Surgery*.—The conference agreement does not include this provision.

(c) *Coverage of Nature Practitioners and Clinical Nurse Specialists*.—The conference agreement includes the Senate amendment.

(d) *Clarifying Coverage of Eyeglasses Provided with Intraocular Lenses Following Cataract Surgery*.—The conference agreement includes the Senate amendment.

(e) *Coverage of Injectable Drugs of Treatment of Osteoporosis*.—The conference agreement includes the House bill.

(f) *Medicare Carrier Notice to State Medical Boards*.—The conference agreement includes the House bill.

(g) *Partial Hospitalization Services*.—The conference agreement includes the Senate amendment with modifications.

(h) *Payments for Certified Registered Nurse Anesthetists*.—The conference agreement includes the Senate amendment.

(i) *Community Health Centers and Rural Health Clinics*.—The conference agreement includes the House bill with amendments.

(j) *Coverage of Mental Health Professional Services*.—The conference agreement does not include this provision.

(k) *Technical Amendments Relating to Physician Payment and Resource Based Relative Value Scale*.—

(1) *Prohibition of Comparability Adjustments*.—The conference agreement includes the Senate amendment.

(2) *Periodic Review of the Resource Based Relative Value Scale*.—The conference agreement includes the Senate amendment.

(3) *Volume Performance Standard*.—The conference agreement includes the Senate amendment.

(4) *Elimination of Restriction on Incorporation of Time in Visit Codes*.—The conference agreement includes the Senate amendment.

(5) *Treatment of Price in Determining Volume Performance Standard Rates of Increase*.—The conference agreement includes the Senate amendment.

(6) *Other Resource Based Relative Value Scale Technical Amendments*.—The conference agreement includes a combination of the House provision and the Senate amendment.

(1) *Minor and Technical Amendments*.—The conference agreement includes the House provision with technical changes.

In addition, the conference report includes other provisions:

(1) *Revise Information on Part B Claim Forms*.—The conference agreement includes a provision modifying the ownership referral

reporting requirement on Part B claims form to delete the requirement that the claim include information on whether the referring physician is an interested investor. The effective date for the reporting requirement is October 1, 1990;

(2) *Disclosure of Ownership of Suppliers.*—The conference agreement includes a disclosure of ownership provision limited to suppliers and mobile labs.

(3) *Consultation for Social Workers.*—Clinical social workers would be required to consult with a patient's attending physician in accordance with criteria developed by the Secretary;

(4) *Clarification of Extension of Municipal Health Service Project Waivers.*—The extension of the waiver granted to municipal health services demonstrations under OBRA '89 is revised to clarify that the waivers are extended under the same basis and under the same conditions as the waivers were conducted on January 1, 1990.

Coverage of Screening Mammography

Present law

(a) *In General.*—Medicare general does not cover preventive services; therefore, routine screening mammograms have not been covered.

Medicare covers radiologic mammograms as a diagnostic test if: 1) a patient has distinct signs and symptoms for which a mammogram is indicated; 2) a patient has a history of breast cancer; or 3) a patient is asymptomatic, but on the basis of the patient's history and other factors the physician considers significant, the physician's judgment is that it is appropriate.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) included a provision to expand Medicare coverage to include mammography screening. The benefit was repealed with the repeal of the Act in 1989 (P.L. 100-234).

(b) *Frequency Limits.*—No provision.

(c) *Screening Mammography Quality Standards.*—No provision.

(d) *Payment Rules.*—No provision.

(e) *Limiting Charges of Nonparticipating Physicians.*—No provision.

House bill

No provision.

Senate amendment

No provision.

Conference agreement

(a) *In General.*—The conference agreement provides for Medicare coverage of "screening mammography," defined as a radiologic procedure provided to a woman for the early detection of breast cancer, including a physician's interpretation of the results of the procedure. Coverage would be effective for screening mammography performed on or after January 1, 1991.

Medicare payment for screening mammography would be made (1) only for screening mammography conducted consistent with frequency limits: (2) only if the screening mammography meets qual-

ity standards; (3) if the amount of the Medicare payment, subject to the Part B deductible, is equal to 80% of the lesser of the actual charge for the screening, the radiologic fee schedule amount, or the limit established for screening mammography, as described below.

The conference agreement requires the Secretary, in developing fee schedules for radiologists, to take into account the frequency limits applicable to screening mammography.

(b) Frequency Limits.—The conference agreement provides for frequency limits as follows. No payment would be made for screening mammography for women under age 35. Payment would be made for only 1 screening mammography for women over 34 but under 40. For women over 39 but under 50, payment would be made annually (provided 11 months elapse after the last screening) for those at high risk of developing breast cancer (determined using factors identified by the Secretary), or biennially (provided 23 months elapse after the last screening) for those not at high risk of developing breast cancer. For women over 49 but under 65, payment would be made annually (provided 11 months elapse after the last screening). For woman over 64, payment would be made biennially (provided 23 months elapse after the last screening).

The Secretary, in consultation with the Director of the National Cancer Institute, is required to review periodically the appropriate frequency for performing screening mammography, based on age and other factors the Secretary determines are pertinent. The Secretary is authorized to revise from time to time the frequency with which screening mammography may be paid for, but prohibits such revision before January 1, 1992.

(c) Screening Mammography Quality Standards.—The conference agreement requires the Secretary to establish quality standards to ensure the safety and accuracy of covered screening mammographies. The standards would include the following requirements:

(1) The equipment used must be specifically designed for mammography and must meet radiological standards established by the Secretary for mammography;

(2) The mammography must be performed by an individual who is either licensed by the State to perform such procedures, or is certified as qualified to perform such procedures by an appropriate organization (as specified by the Secretary in regulations);

(3) The mammography results must be interpreted by a physician who is either certified as qualified to interpret radiological procedures by an appropriate board (as specified by the Secretary in regulations), or is certified as qualified by a program (recognized by the Secretary in regulation as assuring the physician's qualifications); and

(4) There are satisfactory assurances that the results of the first screening mammography for which Medicare makes payment will be placed in permanent medical records maintained for the woman.

The conference agreement also requires the Secretary, when consulting with appropriate State agencies and recognized national listing or accrediting bodies or local agencies to develop conditions of participation for providers of services, to consult about whether screening mammography meets the quality standards provided in

this section. The Secretary is required to make agreements with able and willing States to use State (or local) agencies to determine whether screening mammography meet the quality standards provided in this section. If the Secretary finds that accreditation of an entity by the American Osteopathic Association or any other national accreditation body provides reasonable assurances that any or all of the conditions of this section related to quality standards for screening mammography are met, the Secretary is authorized to treat such entity as meeting those conditions.

(d) *Payment Rules.*—The conference agreement provides for the following payment rules. The amount of the Medicare payment, subject to the Part B deductible, is equal to 80% of the lesser of: (1) the actual charge for the screening mammography, (2) the radiologic fee schedule amount, or (3) the limit established for screening mammography. The limit is \$55 for screening mammographies performed in 1991; for those performed in subsequent years, the limit would be the prior year's limit, increased by the percentage increase in the MEI (Medical Economic Index).

The Secretary is required to review from time to time the appropriateness of the limit. For screening mammographies performed after 1992, the Secretary is authorized to reduce the limit, either nationally or in any area, to an amount that the Secretary estimates is necessary to ensure that screening mammographies of an appropriate quality are readily and conveniently available during the year.

The Secretary is required to provide for an appropriate allocation of the limit between professional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where the claim for professional services is separate from that for the radiologic procedure.

(e) *Limiting Charges of Nonparticipating Physicians.*—The conference agreement provides that for covered screening mammographies performed on or after January 1, 1991, if a nonparticipating physician or supplier provides the screening to an individual covered by Part B, the physician or supplier may not charge the individual more than the limiting charge or, if less, as defined in Section 1834(b)(5)(B) or Section 1848(g)(2). The limiting charge would be 125% of the screening mammography limit in 1991, 120% in 1992, and 115% after 1992. The Secretary is authorized to apply sanctions in accordance with Section 1842(j)(2) against physicians or suppliers who knowingly and willfully impose charges in violation of these limits.

PARTS A AND B

1. End Stage Renal Disease (Sections 12201 and 4123 of House Bill and Sections 6150 and 6151 of Senate Amendment)

Present law

(a) *Payments to Dialysis Facilities.*—Hospital and free-standing facilities are reimbursed under a composite rate formula that is weighted to reflect the proportion of patients dialyzing at home and the proportion of patients dialyzing in a facility. Under the composite rate, the current average payment is estimated at \$125

per dialysis treatment in free-standing facilities and \$129 per dialysis treatment in hospital units.

The Omnibus Reconciliation Act of 1989 required the Secretary to maintain the current composite rates through October 1, 1990 and prohibited the Secretary from changing the rates in effect as of September 30, 1990 unless prescribed regulatory procedures are followed.

(b) *Self-Administration of Erythropoietin (EPO).*—Medicare currently provides coverage for erythropoietin for Medicare renal dialysis patients who meet specified medical criteria. Self-administration of the drug is not covered. For patients who dialyze in a facility, payment is made to the facility in the form of an add-on to the composite rate. In order for patients who dialyze at home to receive Medicare coverage, the drug must be administered by a physician.

(c) *Payments for Erythropoietin.*—Medicare currently provides coverage for erythropoietin for renal dialysis patients if the drug is not self-administered. For patients who dialyze in a facility, payment is made to the facility in the form of an add-on to the composite rate. The Health Care Financing Administration (HCFA) established an add-on rate of \$40 per treatment for dosages under 10,000 units and \$70 for dosages of 10,000 units and above.

HCFA's payment rate was based upon average dose levels of 5,000 units. More recent data indicate that average dose levels have dropped to 2,700 units per treatment. The Medicare program pays eighty percent of these amounts, while beneficiaries are responsible for the remaining 20 percent. Facilities and physicians are prohibited from billing the beneficiary for additional amounts.

Physicians who administer the drug to home dialysis patients are reimbursed for the cost of the drug, plus a \$2 administrative fee per treatment for supplies. The methods of reimbursing physicians for drug costs vary by carrier.

(d) *Demonstration for Staff-Assisted Home Hemodialysis.*—Staff assistants for home dialysis ESRD patients are not specifically reimbursed under law. Until February 1, 1990, Method II suppliers were paid on the basis of reasonable charges, and some suppliers provided staff assistants without additional compensation. OBRA '89 limited reimbursement to Method II suppliers to the same level paid to Method I providers, effective February 1, 1990. Some suppliers who had been providing staff assistants under reasonable charge reimbursement ceased doing so when Method II payments were capped. The Secretary subsequently decided, under experimental authority granted under Section 1881(f)(2) to provide staff assistants to a limited number of patients who had such assistants prior to the time when Method II reimbursement was capped.

House bill

(a) *Payments to Dialysis Facilities.*—Section 12201. Requires the Secretary to maintain the composite rate for hospital-based and free-standing dialysis facilities at a rate equal to the rate in effect May 13, 1986, reduced by \$2.00 and increased by the amount of the reduction imposed by the continuation of the sequestration order enacted for FY 90 in OBRA 89. 10/17/90

Section 4123. No provision.

(b) *Self-Administration of Erythropoietin (EPO).*—No provision.

(c) *Payments for Erythropoietin.*—Section 12201. The Secretary would be directed to revise payments for erythropoietin. Payments would be based upon 1,000 unit increments. The Secretary would make payments of no more than \$11.00 per 1,000 units up to a maximum payment of \$70 per dose. The Secretary would continue to make payments as an add-on to the composite rate. Beginning in FY 92, the payment level for erythropoietin would be indexed to the implicit price deflator for the gross national product. 10/17/90

Section 4123. No provision.

(d) *Demonstration for Staff-Assisted Home Hemodialysis.*—Section 12201. No provision.

Section 4123. Directs the Secretary to establish a demonstration project to determine whether the services of a home dialysis aide can be covered under Medicare in a cost-effective manner that ensures patient safety. The demonstration is to be established within 6 months of enactment.

Under the demonstration, the Secretary is to make payments for 2 years to a Medicare provider (other than a skilled nursing facility) in an urban area and to a provider (other than a skilled nursing facility) in a rural area for services of a qualified home dialysis aide. Payments will be prospectively determined by the Secretary and made on a per treatment basis, except that the payment may not exceed the amount that would be paid by Medicare for ambulance service for transporting a patient to and from a dialysis facility.

An individual is eligible to participate in the demonstration if: (1) he or she is a Medicare ESRD beneficiary; (2) the attending physician certifies that the individual suffers from a permanent, serious medical condition (as specified by the Secretary) that precludes travel to and from a provider of services or a renal dialysis facility; and (3) no family member or other individual is available or able to provide assistance.

Home dialysis aides must meet the following requirements in order to be qualified to participate in the demonstration: (1) meets requirements established by the Secretary for home dialysis aides providing medical assistance and (2) meets any applicable standards established by the State in which the aide is providing services.

Not later than 6 months after the expiration of the demonstration, the Secretary is to submit a report to Congress on the results of the project, and is to include recommendations regarding appropriate eligibility criteria and cost control mechanisms.

An authorization of \$2 million is made to carry out the demonstration project.

Effective date: Section 12201. Provision (a) takes effect for services furnished on or after January 1, 1992. Provision (c) applies to services provided on or after January 1, 1991.

Section 4023. Enactment

Senate amendment

(a) *Payments to Dialysis Facilities.*—Section 6150. The Secretary would be required to establish a rate for hospital-based and free-standing dialysis facilities at not less than the rate in effect Sep-

tember 30, 1990 for the period beginning October 1, 1990 and before October 1, 1993.

The Prospective Payment Assessment Commission would be directed to study the cost, services and profits associated with various dialysis modalities provided to ESRD patients. The Commission would be required to make recommendations to Congress regarding the method or methods and the levels at which the payments made to dialysis facilities for the facility component of dialysis services should be established for FY 93, and the methods used to update payments for subsequent years. In making recommendations, the Commission is to consider: (1) hemodialysis and other modalities of treatment; (2) the appropriate services to be included in such payments; (3) the adjustment factors to be incorporated, including facility characteristics such as hospital versus free-standing facilities, urban versus rural, size and mix of services; (4) adjustments for labor and non-labor costs; (5) comparative profit margins for all types of renal dialysis providers of service and renal dialysis facilities; (6) adjustments for patient complexity, such as age, diagnosis, case mix, and pediatric services; (7) disproportionate share adjustment; (8) educational cost adjustment; and (9) efficient costs related to high quality of care and positive outcomes for all treatment modalities.

The Commission's report is due to the Senate Committee on Finance and the House Committees on Ways and Means and Energy and Commerce by June 1, 1992. Not later than March 1 before the beginning of each fiscal year, beginning with fiscal year 1993, the Commission is to report its recommendations on a appropriate change factor to be used in updating payments for services rendered that fiscal year. The Commission is to consider conclusions and recommendations from the Institute of Medicine study.

(b) *Self-Administration of Erythropoietin (EPO).*—Section 6151. Coverage for erythropoietin and items related to its administration would be allowed for home renal dialysis patients who are competent to use the drug without medical or other supervision, subject to methods and standards established by the Secretary through regulation for the safe and effective use of the drug.

Erythropoietin, including self-administered erythropoietin, would not be included as a dialysis service for payment purposes under a prospective payment amount or comprehensive fee established for dialysis services. Payment for erythropoietin provided by a physician would be made on a reasonable charge basis. Payment for erythropoietin provided by a provider of services or a renal dialysis facility would be made in an amount determined by the Secretary. Payments to Method II suppliers of home dialysis supplies and equipment for self-administration of erythropoietin may be made if the Secretary determines that a patient can safely and effectively administer the drug in accordance with standard established by the Secretary.

Payment to Method II suppliers for erythropoietin that is self-administered is to be determined in the same manner as payment to a renal dialysis facility for the drug.

(c) *Payments for Erythropoietin.*—Section 6150 and 6151. No provision.

(d) *Demonstration for Staff-Assisted Home Hemodialysis.*—Section 6151. Authorizes the Secretary to make payments to approved ESRD providers and facilities for the cost of home dialysis support services furnished to home dialysis patients under the direct supervision of the provider or facility. The Secretary is to establish a prospective method for determining the amount of payment to be made for home hemodialysis staff assistance furnished by a provider of services for a dialysis episode. The payment amount is to be in addition to the composite rate paid to the provider or facility for dialysis services.

The payment amount is to be calculated as follows. The national median hourly wage for a home hemodialysis staff assistant is multiplied by the national median time expended in the provision of home hemodialysis staff assistant services. The national median hourly wage and the national median average time expended for home hemodialysis services is to be determined annually based on the most recent data available. The national median hourly wage is to be the sum of 65 percent of the national median hourly wage for a licensed practical nurse and 35 percent of the national median hourly wage for a registered nurse.

Two-thirds of the labor portion of the composite rate applicable to the provider or facility (as adjusted to reflect area differences in wages) is to be subtracted from the product of the national median time expended in staff assistant services and the national median average time expended. The result is multiplied by the factor by which the labor portion of the composite rate is adjusted for area differences in wages.

Home hemodialysis staff assistance means the following services: (1) technical assistance with the operation of a hemodialysis machine in the patient's home and with the patient's care during in-home hemodialysis; and (2) administration of medications in the patient's home to maintain the patency of the extra corporeal circuit. Home hemodialysis staff assistants are qualified to receive Medicare reimbursement if they: (1) have met the minimum qualifications specified by the Secretary; and (2) meet the minimum qualifications specified in State law in the State where the aide is providing services.

Eligible patients means individuals who: (1) a physician certifies as being confined to a bed or wheelchair and who can not transfer themselves from a bed to a chair; or (2) have serious medical conditions (as specified by the Secretary) which would be exacerbated by travelling to and from a dialysis facility; and (3) are eligible for Medicare ambulance transportation to receive routine maintenance dialysis services, and based on the patient's medical condition, there is reasonable expectation that the transportation will be used by the patient for a period of at least 6 consecutive months, such that the cost of ambulance transportation during this 6-month period can reasonably be expected to meet or exceed the cost of home hemodialysis staff assistance; and (4) have no spouse, relative or other caregiver who either lives with the individual or comes to the individual's house periodically and is willing and able to assist the individual with home hemodialysis; and (5) the Secretary certifies annually as meeting these requirements.

Coverage of home hemodialysis staff assistance takes effect (if at all) after the Secretary establishes a demonstration project to test the cost-effectiveness of furnishing home hemodialysis staff assistance. The demonstration is to begin January 1, 1991 and continue through December 31, 1993, or the date that occurs the same number of days after such date as elapsed between January 1, 1991 and the first day on which services were furnished under the project. As of the date of enactment, any individual receiving staff assistance under the Secretary's experimental authority is deemed to be eligible for the demonstration, and any individual participating in the demonstration as of December 31, 1993, or the end of the demonstration, will continue to be eligible for home hemodialysis staff assistance under the same terms and conditions as under the demonstration. If the Secretary determined that it is not cost-effective to furnish home dialysis staff assistance, the demonstration will terminate as of December 31, 1993.

The number of eligible patients participating in the demonstration may not exceed 550 during any month, except that one eligible patient must be admitted to the demonstration for each individual ceasing to participate in the demonstration. The Secretary may implement the demonstration on a nationwide basis or at specific sites.

The Secretary is directed to transmit a preliminary report to the House Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee not later than January 15, 1993, and a final report by December 31, 1993.

Effective date: Sections 6150 and 6151. Provisions (a) and (b) apply for services provided on or after January 1, 1991. Provision (d) takes effect, if at all, after the demonstration project establishes the cost-effectiveness of home hemodialysis staff assistance.

Conference agreement

1. End Stage Renal Disease

(a) *Payments to Dialysis Facilities.*—The conference agreement includes the House bill with an amendment. The Secretary would be required to maintain the composite rate in effect on September 30, 1990, without regard to reductions imposed in Section 11102 of OBRA '89, increased by \$1.00, for services provided on or after January 1, 1991. The Prospective Payment Assessment Commission would be required to study the cost, services, and profits associated with various dialysis modalities provided to ESRD patients.

(b) *Self-Administration of Erythropoietin.*—The conference agreement includes the Senate amendment with a modification. The conference agreement does not preclude the Secretary from establishing guidelines that permit Method II suppliers to provide home dialysis patients with erythropoietin. Effective for services rendered on or after July 1, 1991.

(c) *Payments to Erythropoietin.*—The conference agreement includes the House bill with modifications. The \$70 cap on payment would be eliminated. Payments would be based on 1,000 unit increments of erythropoietin rounded to the nearest 100 units.

(d) *Demonstration for Staff-Assisted Home Hemodialysis.*—The conference agreement includes the Senate amendment with amend-

ments. The demonstration is to begin within nine months of enactment and to continue for three years. The Secretary would conduct a study to determine whether staff assisted home hemodialysis services are cost effective and safe for qualified ESRD beneficiaries. The study would be designed with a treatment and comparison group; the treatment group would be limited to 800 individuals receiving staff assisted dialysis services during the demonstration. The Secretary would be required to submit an interim report to Congress by December 1, 1992 and a final report by December 31, 1995. The Secretary's final report is to include recommendations regarding appropriate eligibility criteria and cost control mechanisms. Expenditures for the demonstration are to be made from the Federal Supplementary Medical Insurance (SMI) Trust Fund. Expenditures from the SMI trust fund for the demonstration are expected to be \$14 million from FY 91 to FY 95.

2. Extension of Secondary Payer Provisions (Sections 12202, 4121, and 4122(b) of the House bill; Section 6152 of the Senate amendment)

Present law

(a) *Extension of Transfer of Data.*—Medicare is a secondary payer under specified circumstances when Medicare beneficiaries are covered by other third party payers. Medicare is secondary payer to automobile, medical, no-fault and liability insurance. In addition, Medicare is secondary payer to certain employer group health plans for items and services provided to aged and disabled beneficiaries, and to end-stage renal disease (ESRD) beneficiaries during the first 12 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

The Department of Health and Human Services (HHS) identifies Medicare secondary payer cases in the following ways: beneficiary questionnaires; provider identification of third party coverage when services are provided; Medicare contractor screening and data collection and exchange; and data transfers with other Federal and State agencies.

As a result of changes made in OBRA 1989 (P.L. 101-239), HHS is provided a 2-year period for matching Internal Revenue Service (IRS) tax records to records of the Social Security Administration (SSA) and the Health Care Financing Administration (HCFA) to identify working beneficiaries and their spouses to improve the identification and collection of Medicare secondary payer cases. Medicare contractors are required to use this new information to contact employers to determine whether the employer provided health coverage, during what time period, and the nature of such coverage. Employers are required to respond to such inquiries within 30 days.

Current restrictions on the disclosure of information under the Internal Revenue Code and the Privacy Act also apply to the new information provided by SSA and IRS to HCFA.

The present law requirement that employers respond to inquiries from Medicare contractors about employer coverage of beneficiaries and their spouses expires for inquiries made after September 30, 1991. In addition, the present law requirement that 1) the Treasury

Secretary respond to requests from SSA to disclose IRS taxpayer identification information about Medicare beneficiaries and their spouses, and 2) SSA respond to requests from HCFA to disclose such information expires for requests made after September 30, 1991. The Treasury Secretary is not required to respond to requests made before September 30, 1991, for information relating to 1990 or thereafter, and SSA is not required to respond to requests made before September 30, 1991, for information relating to 1991 or thereafter.

(b) Extension of Application to Disabled Beneficiaries.—OBRA 1986 (P.L. 99-509) required that Medicare be the secondary payer for disabled Medicare beneficiaries who are covered by a "large group health plan" for items and services furnished on or after January 1, 1987, and before January 1, 1992. "Large group health plan" is defined as an employer or employee organization plan of an employer that employs at least 100 employees. This provision expires January 1, 1992.

(c) Extension of Renal Disease Period.—Medicare is the secondary payer, for a 12-month period, for beneficiaries who are entitled to Medicare solely on the basis of end-stage renal disease and who are covered by an employer-based group health plan. The 12-month period begins with the earlier of 1) the month in which the individual initiates a regular course of renal dialysis, or 2) the month in which an individual who receives a kidney transplant could become entitled to Medicare.

A technical aspect of the law effectively limits Medicare's secondary status to the first 9 months of an individual's Medicare entitlement. This is because entitlement to Medicare as an ESRD beneficiary begins with the third month after the month in which a regular course of dialysis is initiated (except in the case of kidney transplant recipients), while the law requires employer plans to be primary for the 12-month period beginning with the month dialysis is initiated.

(d) Prohibiting Certain Employer Marketing Activities.—No provision.

House bill

(a) Extension of Transfer of Data.—

Section 12202. Amends the Social Security Act to extend through September 30, 1995, the requirement that employers must respond to inquiries from Medicare contractors about employer coverage of beneficiaries and their spouses. Amends the Internal Revenue Code to extend through September 30, 1995, the requirement that the Treasury and SSA respond to requests concerning taxpayer information. For requests made before September 30, 1995, provides that the Treasury would not be required to respond to requests for information for 1994 and thereafter, and SSA would not be required to respond to requests for information relating to 1995 or thereafter.

Section 4121. Amends the Social Security Act to eliminate the September 30, 1991 sunset of the requirement that employers must respond to inquiries from Medicare contractors.

(b) Extension of Application to Disabled Beneficiaries.

Section 12202. Amends the Social Security Act to extend the application of this provision to items and services furnished before October 1, 1995.

Section 4121. Eliminates the January 1, 1992 sunset of this provision.

(c) Extension of Renal Disease Period.—

Section 12202. No provision.

Section 4121. Extends the period during which employer-based health coverage is the primary payer for ESRD beneficiaries from 12 to 18 months.

(d) Prohibiting Certain Employer Marketing Activities.—

Section 12202. No provision.

Section 4122(b). Provides that it would be unlawful for an employer or other entity to offer any financial or other incentive for an individual not to enroll (or to terminate enrollment) under a group health plan which would (in case of such enrollment) be a primary plan, unless such incentive is also offered to all individuals who are eligible for coverage under the plan.

Provides that entity that violates this requirement would be subject to a civil money penalty of not to exceed \$5,000 for each such violation. Provides that certain provisions of Section 1128A of the Social Security Act would apply to the civil money penalty.

Effective date:

Section 12202.—Enactment, except (a) related to requests made of the Treasury would apply to requests made on or after enactment.

Sections 4121 and 4122(b). Enactment, except (c) applies to group health plans for plan years beginning on or after January 1, 1991, and (d) applies to incentives offered on or after enactment.

Senate amendment

*(a) Extension of Transfer of Data.—*Identical to Section 12202.

*(b) Extension of Application to Disabled Beneficiaries.—*Identical to Section 12202.

*(c) Extension of Renal Disease Period.—*Extends the period during which employer-based group health coverage is the primary payer from 12 months to 24 months. Provides that this provision would be effective for items and services furnished on or after February 1, 1991 and before January 1, 1996 (with respect to periods beginning on or after February 1, 1990).

Revises current law to provide that (1) employer-based group health plans would be primary to Medicare during the 24-month period that begins with the first month in which the individual becomes entitled to Medicare benefits on the basis of ESRD, and (2) such plans would not be prohibited from being secondary payer during a period occurring before or after this 24-month period.

Requires the Comptroller General to study and report to the Committees on Ways and Means, Energy and Commerce, and Finance on the impact of the extension to 24 months on individuals eligible for Medicare on the basis of ESRD. Requires the report to include information relating to:

(1) the number and geographic distribution of such individuals for whom Medicare is secondary;

(2) the amount of savings to Medicare achieved annually from this provision;

(3) the effect on access to employment, and employ-based health insurance, for such individuals and their family members (including coverage by employment-based health insurance of Medicare's cost-sharing requirements after employment-based insurance becomes secondary); and

(4) the effect on the amount paid for each dialysis treatment under employment-based health insurance; and

(5) the effect on cost-sharing requirements under employment-based health insurance (and on out-of-pocket expenses of such individuals) during the period for which Medicare is secondary.

Requires the Comptroller General to submit a preliminary report not later than January 1, 1993, and a final report not later than January 1, 1995.

(d) Prohibiting Certain Employer Marketing Activities.—No provision.

Effective date: Enactment, except the provisions in (a) relating to requests made of the Treasury would apply to requests made on or after enactment; those in (c) extending the employer's primary period for ESRD beneficiaries from 12 to 24 months, and starting the period with the first month in which the individual becomes entitled to Medicare benefits on the basis of ESRD—would apply to periods beginning on or after February 1, 1990; those in (c) making employer plans primary for ESRD beneficiaries would be effective January 1, 1992 for beneficiaries whose employers have 1,000 or more employees, January 1, 1993 for beneficiaries whose employers have 100 or more employees, and January 1, 1994 for all other beneficiaries.

Conference agreement

2. Extension of Secondary Payer Provisions

*(a) Extension of Transfer of Data.—*The conference agreement includes the House bill.

*(b) Extension of Application to Disabled Beneficiaries.—*The conference agreement includes the House bill.

*(c) Extension of Renal Disease Period.—*The conference agreement includes the Senate amendment, with an amendment that the period during which employer-based health coverage would be the primary payer for ESRD beneficiaries is 18 months.

*(d) Prohibiting Certain Employer Marketing Activities.—*The conference agreement includes the House bill.

3. Patient Self-determination (Section 4122 of the House bill; section 6157 of the Senate amendment)

Present law

Most States have enacted legislation defining a patient's rights to make decisions regarding medical care, including: (1) the right to accept or refuse medical or surgical treatment, and (2) the right to

formulate advance directives, such as through the appointment of an agent or surrogate to make decisions on his or her behalf ("durable power of attorney") and written instructions about health care ("living will").

There are no current requirements relating to advance directives under Medicare. There are provisions in current law that establish the basic obligations of hospitals, physicians and other providers under the Medicare program, and that define certain terms. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) which provides "deemed status" to many hospitals under the Medicare program, does require hospitals to have protocols for decision-making on "do not resuscitate" orders. Also, current law requires hospitals, as a condition of participation in the Medicare program, to establish written protocols for the identification of potential donors.

House bill

(a) *Condition of Participation for Home Health Agencies.*—No provision.

(b) *As a Contractual Condition for HMOs and CMPs.*—Provides that Medicare contracts with HMOs/CMPs include a provision that the organization will comply with requirements relating to patient advance directives, including living wills and other instructions recognized under State law relating to care when an individual is incapacitated. Requires that organizations have written policies and procedures to (a) inform all adult enrollees at the time of enrollment of their right to accept or refuse treatment and to execute an advance directive and of the organization's policies on implementation of that right, (b) document in medical records whether or not an individual has executed an advance directive, (c) not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive, (d) comply with State laws on advance directives, and (e) provide education for staff and the community on advance directives. Requires other types of prepaid organizations, as a condition for Medicare payment, to provide assurances that they will comply with the same requirements.

(c) *Requiring Provision of Information Regarding Patient's Rights.*—No provision but see (b) above.

(d) *Enforcement.*—Compliance with these provisions is a Medicare contract requirement.

(e) *Assistance in Development and Distribution of Patients' Rights Document.*—No provision.

(f) *Inclusion of Certain Information in Annual Medicare Beneficiary Mailing.*—No provision.

(g) *Study.*—No provision.

(h) *Public Education Project.*—No provision.

Effective date: Applies to Medicare HMO (risk and other) contracts as of the first day of the first month beginning more than one year after enactment.

Senate amendment

(a) *Condition of Participation for Home Health Agencies.*—Amends the Medicare conditions of participation for home health

agencies to require that such agencies maintain written policies and procedures respecting advance directives.

(b) *As a contractual condition for HMOs and CMPs.*—Requires that as a condition for a Medicare contract that each risk-sharing HMO/CMP and other type of prepaid organization meet the requirements relating to maintaining written policies and procedures respecting advance directives.

(c) *Requiring Provision of Information Regarding Patient's Rights.*—Amends the provision of the Social Security Act relating to Medicare provider agreements. Requires that hospitals, skilled nursing facilities, home health agencies, hospice programs, HMOs/CMPs, other prepaid organizations, and comprehensive outpatient rehabilitation facilities comply with new provisions relating to maintaining written policies and procedures with respect to all adult individuals receiving medical care.

Requires that adult individuals be provided written information concerning: (1) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and (2) the policies of the provider or HMO/CMP respecting the implementation of such rights. Requires the provider or HMO/CMP to inquire of an individual (or a family member) whether the individual has executed an advanced directive and document in the individual's medical record the response to the inquiry. Requires the provider or HMO/CMP to ensure compliance with requirements of State law respecting advance directives at facilities of the provider or HMO/CMP, and to provide (individually or with others) for education for staff on issues concerning advance directives. Defines advanced directive to mean a written instruction, such as a living will or durable power of attorney for health care, recognized under State law and relating to the provision of such care when the individual is incapacitated.

Prohibits a provider or organization from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advanced directive. Provides that this is not to be construed as requiring the provision of care which conflicts with an advanced directive.

(d) *Enforcement.*—Compliance with these provisions is required as part of the Medicare provider agreements and Medicare contracts with HMOs/CMPs and other prepaid plans.

(e) *Assistance in Development and Distribution of Patients' Rights Document.*—Requires the Secretary to assist, in each State, an appropriate State agency, association, or private entity in developing a State-specific document that describes patients' rights in the State that could be distributed to providers and physicians for use in complying with the requirements that they provide patients' rights information to their patients. Requires the Secretary to assist such agency, association, or entity in the distribution of copies of the documents.

(f) *Inclusion of Certain Information in Annual Medicare Beneficiary Mailing.*—Requires the Secretary to mail information to Social Security recipients, add a page to the Medicare handbook with respect to the provisions of the Act, and provide for and install a na-

tionwide, toll-free informational number to provide State agencies, private entities, and Medicare and Medicaid eligible individuals with information regarding the option to execute advance directives and the rights of individuals as provided for under this Act.

(g) *Study*.—Requires the Secretary to conduct a study or enter into an agreement with a private entity to conduct a study and submit a report to Congress with respect to the implementation of directed health care decisions. Requires that the study: (1) evaluate the experience of practitioners, providers, and government regulators in complying with the provisions of this Act; (2) assess the awareness and utilization of advance directives as a result of this Act; (3) investigate methods of encouraging reciprocity among States in the enforcement of advance directives; (4) report on the manner in which treatment decisions are made in the absence of advance directives; and (5) make such recommendations for legislation as may be appropriate to carry out the purposes of this Act. Requires the study and report to be submitted to Congress no later than 4 years after enactment.

(h) *Public Education Project*.—Requires the Secretary to develop and implement a national campaign to inform the public of the option to execute advance directives and of a patient's right to participate and direct health care decisions. Requires the Secretary to develop or approved nationwide informational materials that would be distributed by providers under the requirements of this Act, to inform the public and the medical and legal profession of each person's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives.

Effective date: Applies with respect to services furnished on or after the first day of the first month beginning more than one year after enactment, except the provisions affecting Medicare HMO contracts apply to contracts as of the first day of the first month beginning more than one year after enactment.

Conference agreement

3. *Patient Self-Determination/Living Wills*.—The conference agreement includes the Senate bill with modifications. The agreement provides that the provider or organization provide written information to each individual which includes the written policies respecting the implementation of such rights. The provider or organization is required to document in the individual's medical record whether or not the individual has executed an advanced directive. The provider organization is required to ensure compliance with requirements of State law whether statutory or as recognized by the courts of the State respecting advance directives at facilities of the provider or organization. The conference agreement specifies the times at which the written information must be provided to an adult individual, and modifies the definition of advanced directive. It further provides that nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive. The conference agreement does not

include the study of the implementation of directed health care decisions or the public education project.

4. Health Maintenance Organizations (Section 4122 of the House bill; section 6153 of the Senate amendment)

Present law

(a) Restrictions on Incentive Payments to Physicians.—OBRA 1986 prohibited hospitals and health maintenance organizations (HMOs) or similar entities with a risk contract under Medicare or Medicaid from making payments to a physician, directly or indirectly, as an inducement to reduce or limit services provided to beneficiaries or enrollees. For HMOs, the effective date has been delayed until April 1, 1991.

(b) Revisions in Methodology Used to Determine AAPCC.—The Secretary is required to annually determine, and announce in a manner intended to provide notice to interested parties, a per capita rate of payment for each class of beneficiaries enrolled with an HMO/CMP on a risk basis. This notice is required to be promulgated by September 7 of each year, with an explanation of the methodology due 45 days earlier (beginning with the announcement for 1991). The per capita rate of payment must equal 95 percent of the adjusted average per capita cost (AAPCC), the projected average cost in the coming year of providing Medicare benefits to a comparable group of beneficiaries who are not enrolled in an HMO/CMP and receive care on a fee-for-service basis.

(c) Application of National Coverage Decisions to Risk-Sharing Contracts.—HMOs/CMPs are required to provide the full scope of Medicare services to enrolled beneficiaries. From time to time the Secretary promulgates national coverage decisions, which determine whether specific procedures or items may be paid for under Medicare, and under what conditions.

(d) Permitting Continuous Enrollment of Certain Retirees.—No provision.

(e) Application of 50 Percent Limit on Medicare/Medicaid Enrollment.—

No more than 50 percent of enrollees in an HMO/CMP with a Medicare risk-sharing contract may be Medicare or Medicaid beneficiaries; the Secretary may waive this requirement for an HMO/CMP serving an area with a high Medicare and Medicaid population. The requirement may also be waived for the first 3 years of a contract with an HMO/CMP owned and operated by a governmental entity if the HMO/CMP is making reasonable efforts to enroll members who are not Medicare or Medicaid beneficiaries. (A separate limit of 75 percent Medicare and Medicaid enrollment applies to HMOs contracting with Medicaid.) In addition, an HMO/CMP must have at least 5,000 members to qualify for a risk-sharing contract, unless it primarily serves members residing outside urbanized areas.

(f) Prohibiting Certain Employer Marketing Activities.—No provision.

(g) Patient's Right to Participate in and Direct Health Care Decisions.—No provision.

(h) *Extension of Waivers for Social Health Maintenance Organizations.*—No provision.

(i) *Study of Chiropractic Services.*—No provision.

House bill

(a) *Restrictions on Incentive Payments to Physicians.*—No provision.

(b) *Revisions in Methodology Used to Determine AAPCC.*—No provision.

(c) *Application of National Coverage Decisions to Risk-Sharing Contracts.*—No provision.

(d) *Permitting Continuous Enrollment of Certain Retirees.*—Provides that if an individual is enrolled in an HMO/CMP under a health plan sponsored by the individual's employer or a spouse's employer, and if the individual or spouse retires, the individual may be enrolled retroactively under a Medicare risk-sharing contract with that HMO/CMP. The enrollment may be effective as of the first month of retirement if it occurs no later than 3 months after the date of retirement.

(e) *Application of 50 Percent Limit on Medicare/Medicaid Enrollment.*—

(1) *Waiver of 50/50 Rule.*—No provision.

(2) *Temporary Waiver for Related Entities.*—No provision.

(3) *Waiver of Certain HMO Requirements.*—No provision.

(f) *Prohibiting Certain Employer Marketing Activities.*—See item 2, above, for provision relating to Medicare as a secondary payer.

(g) *Patient's Right to Participate in and Direct Health Care Decisions.*—See item 3, above, for provisions relating to advance directives in HMOs.

(h) *Extension of Waivers for Social Health Maintenance Organizations.*—See item 7, below, for provisions relating to extension of the social health maintenance organization (SHMO) waivers.

(i) *Study of Chiropractic Services.*—No provision.

Effective date: Enactment.

Senate amendment

(a) *Restrictions on Incentive Payments to Physicians.*—Requires that Medicare risk-sharing contracts with HMOs or competitive medical plans (CMPs) prohibit the organization from operating a physician incentive plan unless the following requirements are met: (1) no specific payment may be made to physicians as an inducement to withhold or limit services to specific enrollees, and (2) if physicians or physician groups are placed at serious risk for services than their own, the HMO/CMP must provide adequate stop-loss protection (as determined by the Secretary taking into account the size of the group and the number of enrollees served) and must periodically survey enrollees to ensure that they have adequate access and are satisfied with the quality of services. Requires the HMO/CMP to provide the Secretary with sufficient information about the incentive plan to determine compliance. Provides that, if the Secretary determines that a violation of these requirements has occurred, the Secretary may impose a \$25,000 civil monetary penalty for each such determination and/or suspend new enrollments or payment for new enrollees until satisfied that the viola-

tion will not recur. Repeals the OBRA 1986 prohibition of incentive payments by HMOs/CMPs with Medicare risk-sharing contracts.

(b) Revisions in Methodology Used to Determine AAPCC.—Requires the Secretary to submit a proposal for revisions in the HMO/CMP payment methodology to Congress by January 1, 1992, with the revisions to take effect for rate years beginning January 1, 1993. Requires that the proposed methodology improve the prediction of actual service use and expenditures for enrollees of each HMO/CMP, either through modification of the AAPCC formula to include such factors as health status adjusters or prior utilization measures or through use of a new alternative to the AAPCC. Requires that the proposal include data to support recommended changes and to show that the revised methodology can account for at least 15 percent of total variation in annual medical expenses for Medicare beneficiaries, as certified by the American Academy of Actuaries. Requires that the Secretary publish the proposal as a notice of proposed rulemaking by March 1, 1992, that the General Accounting Office review the Secretary's proposal and make a recommendation to Congress on appropriate modifications, and that the Secretary issue a final rule taking into account those recommendations by August 1, 1992.

(c) Application of National Coverage Decisions to Risk-Sharing Contracts.—Provides that, if the Secretary issues a national coverage decision in the period between annual HMO/CMP rate announcements, and the Secretary determines that the decision will significantly affect HMO/CMP costs, the decision will not be binding on the HMO/CMP until the first year following the next rate announcement; in the interim, any additional benefits provided as a result of the decision will be paid directly by Medicare on a fee-for-service basis.

(d) Permitting Continuous Enrollment of Certain Retirees.—Similar provision, except requires that, on or before the intended effective date of enrollment, the beneficiary must sign the explanation of enrollees' rights ordinarily required to be furnished to Medicare HMO/CMP enrollees.

(e) Application of 50 Percent Limit on Medicare/Medicaid Enrollment.—

(1) Waiver of 50/50 Rule.—Permits a waiver of the 50 percent limit for an HMO/CMP meeting the following requirements: (i) the HMO/CMP has shown a profit for the last 3 years or, for a new HMO/CMP, the parent company assures its solvency; (ii) the HMO/CMP has had a Medicare risk contract for 3 years or, for a new HMO/CMP, the parent company has operated an HMO for 5 years and has had a Medicare risk contract for 2 years in 2 or more States; (iii) the HMO/CMP has a total of at least 100,000 enrollees; (iv) the HMO/CMP has no serious quality problems, as determined by the Secretary, has agreed to annual quality review by the Secretary; (v) the HMO funds an annual membership survey conducted and reported to the Secretary by an independent survey firm, including satisfaction measures for Medicare enrollees, for Medicare enrollees with a recent hospital discharge, and for Medicare beneficiaries who have disenrolled; (vi) the HMO/CMP provides its Medicare enrollees with special services targeted to the elderly, including a multi-disciplinary geriatric assessment and, for

enrollees dependent in 3 or more activities of daily living for at least 3 months, specified home and community-based long-term care services. Provides that a waiver of the 50-percent rule shall be approved for a 3-year period and that the required additional benefits for Medicare enrollees must also be available for a 3-year period. Requires the Secretary to review the HMO/CMP's compliance with the waiver requirements annually and permits withdrawal of the waiver in the event of noncompliance. Requires the Secretary to evaluate the cost and impact of any waiver, including its impact on the financial viability of the HMO/CMP, and to report to Congress within 2 years after enactment on whether any changes should be made in the 50 percent rule.

(2) *Temporary Waiver for Related Entities.*—Provides that, for a period of 2 years, in determining whether an HMO/CMP that has a Medicare contract meets the 50 percent rule, there may be combined with the HMO/CMP's enrollees the enrollees of an organization related to the HMO/CMP by common ownership and control, if the organization provides services in the same area as the HMO/CMP through essentially the same providers, uses a functionally integrated quality assurance program, and shares specified administrative functions with the HMO/CMP.

(3) *Waiver of Certain HMO Requirements.*—Provides that, in determining whether Managed Care, Inc., an affiliate of CHP (the medical group affiliated with Long Island Jewish Medical Center) meets the 50 percent rule and the 5,000 enrollee minimum, Managed Care may count as enrollees the members of a State-licensed HMO for whom CHP has agreed to assume full financial risk for hospital and physician services. The same enrollees may not be counted by any other organization for the purpose of applying the same tests. Provides that the waiver for Managed Care will expire two years after enactment.

(f) *Prohibiting Certain Employer Marketing Activities.*—No provision.

(g) *Patient's Right to Participate in and Direct Health Care Decisions.*—No provision.

(h) *Extension of Waivers for Social Health Maintenance Organizations.*—No provision.

(i) *Study of Chiropractic Services.*—Requires the Secretary to study the availability of Medicare-covered chiropractic services to HMO enrollees and the arrangements and types of practitioners involved in furnishing such services. Requires that the study be based on contracts entered into or renewed on or after January 1, 1991, and before January 1, 1993. Requires an interim report to The House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance by January 1, 1992, and a final report, including recommendations on changes needed to assure access to such services, by January 1, 1993.

Effective date: (a) Effective January 1, 1992, except that the repeal of the OBRA 1986 prohibition of physician incentive payments is effective on enactment. (c) applies to coverage decisions made on or after September 7, 1990. (d) Applies to individuals enrolling on or after January 1, 1991. All other provisions effective on enactment.

Conference agreement

4. Health Maintenance Organizations

(a) *Restrictions on Incentive Payments to Physicians.*—The conference agreement requires that Medicare risk-sharing contracts with HMOs or competitive medical plans (CMPs) prohibit the organizations from operating a physician incentive plan unless the following requirements are met: (1) no specific payment may be made to physicians as an inducement to withhold or limit services to specific enrollees, and (2) if physicians or physician groups are placed at serious risk for services than their own, the HMO/CMP must provide adequate stop-loss protection (as determined by the Secretary taking into account the size of the group and the number of enrollees served) and must periodically survey enrollees to ensure that they have adequate access and are satisfied with the quality of services. Requires the HMO/CMP to provide the Secretary with sufficient information about the incentive plan to determine compliance. Provides that, if the Secretary determines that a violation of these requirements has occurred, the Secretary may impose a \$25,000 civil monetary penalty for each such determination and/or suspend new enrollments or payment for new enrollees until satisfied that the violation will not recur. Repeals the OBRA 1986 prohibition of incentive payments by HMOs/CMPs with Medicare risk-sharing contracts. The provisions relating to the regulation of incentive plans apply to contract years beginning on or after January 1, 1992. The provision relating to the repeal of the OBRA 1986 prohibition of incentive payments is effective upon enactment.

(b) *Revisions in Methodology Used to Determine AAPCC.*—The conference agreement includes the Senate amendment with modifications. Provides that the proposal include an analysis demonstrating that any proposed or revised payment methodology under this section is effective in explaining at least 15 percent of the variation in health care utilization and costs (as determined in consultation with the American Academy of Actuaries) among individuals enrolled in such organizations.

(c) *Application of National Coverage Decisions to Risk-Sharing Contracts.*—The conference agreement includes the Senate amendment.

(d) *Permitting Continuous Enrollment of Certain Retirees.*—The conference agreement includes the Senate amendment.

(e) *Application of 50 Percent Limit on Medicare/Medicaid Enrollment.*—The conference agreement does not include the Senate amendment.

(f) *Prohibiting Certain Employer Marketing Activities.*—See section relating to Medicare as a secondary payer.

(g) *Patient's Right to Participate in and Direct Health Care Decisions.*—See section relating to provisions relating to advance directives.

(h) *Extension of Waivers for Social Health Maintenance Organizations.*—See section relating to extension of the social health maintenance organization (SHMO) waivers.

(i) *Study of Chiropractic Services.*—The conference agreement includes the Senate amendment.

In addition, the conference agreement extends the limit on charges for out-of-plan and emergency physicians and ESRD services to all out-of-plan and emergency services under Part B.

5. Changes in Medigap Standards (Sections 4301-4309 of the House bill; Section 6155 of the Senate amendment)

Present law

(a) *Simplification of Policies.*—Section 1882 of the Social Security Act requires that in order for a Medigap policy to be certified by the Secretary, it must meet minimum requirements, including benefit requirements, contained in model standards approved by the National Association of Insurance Commissioners (NAIC). In addition, for a State Medigap regulatory program to be approved by HHS, it must apply such minimum requirements.

In its model regulations, the NAIC has defined minimum benefit standards as follows:

(1) coverage of coinsurance for Medicare-eligible hospital expenses for days 61 through 90 in a benefit period; (2) coverage of either all or none of Medicare's inpatient hospital deductible; (3) coverage of coinsurance for Medicare-eligible hospital expenses for Medicare's lifetime reserve days; (4) after exhausting Medicare's lifetime reserve days, coverage of 90 percent of all Medicare-eligible hospital expenses, subject to a lifetime maximum benefit of an additional 365 days; (5) coverage of the Part A blood deductible (3 pints); (6) coverage of Medicare's Part B coinsurance, subject to the Part B deductible; and (7) coverage of the Part B blood deductible (3 pints), subject to the Part B deductible.

The States of Massachusetts, Minnesota, and Wisconsin have implemented their own standardized benefit options.

(b) *Uniform Policy Description.*—Section 1882 of the Social Security Act contains no provision.

The NAIC standards require insurers issuing Medigap policies to provide an outline of coverage that describes the features of the policy, including Medicare's benefits and the policy's benefits, according to a uniform format.

(c) *Prevention of Duplicate Medigap Coverage.*—Section 1882 of the Social Security Act prohibits an individual from knowingly selling a Medigap policy with knowledge that such policy substantially duplicates other health benefits to which the individual is entitled (other than benefits the individual is entitled to under State or Federal law, excluding Medicare). If the Medigap policy pays benefits regardless of other health benefits coverage, such a policy is not considered duplicative. The penalty for non-compliance includes a fine under Title 18 or imprisonment for not more than 5 years, or both, and, in addition or in lieu of such a criminal penalty, a civil money penalty of not to exceed \$5,000 for each such prohibited act.

The NAIC standards require Medigap application forms to contain questions about prior and existing Medigap coverage and Medicaid coverage. Such standards require agents to list on the application form any other health insurance policies they have sold to the applicant. Agents are required to make reasonable efforts to determine the appropriateness of a recommended purchase or replace-

ment. The sale of a Medigap policy to an individual already having such a policy is prohibited unless the combined coverage insures no more than 100 percent of actual medical expenses. The NAIC standards require insurers to report to the States annually by March 1 information on State residents whom the insurer has covered with more than 1 Medigap policy. If the sale involves a replacement, the insurer must give the applicant a notice regarding the replacement, in a format developed by the NAIC, which is to be signed by the applicant and the agent.

(d) *Loss Ratio Requirements.*—Section 1882 of the Social Security Act provides that approved Medigap policies must meet loss ratios (estimated for the period for which rates are computed) of at least 75 percent for group policies and 60 percent for individual policies. Direct response policies (those sold through the mail or by mass media advertising) are permitted to meet the 60 percent individual standard. The law provides that loss ratios are the ratios of incurred claims to earned premiums, estimated in accordance with accepted actuarial principles and practices. Information on actual loss ratios is required to be reported to States on forms conforming to those developed by NAIC, or such ratios will be monitored in an alternative manner approved by the Secretary.

The NAIC standards require that actual loss ratios must be at least 75 percent for group policies and 60/65 percent for individual policies. Direct response policies are required to meet the 75 percent group standard. Policies in force for less than 3 years are not required to meet the standards until their third year. Medigap insurers are required to file annually their rates, rating schedules, and supporting documentation including loss ratios to demonstrate that they comply with the standards. The standards require that premium adjustments be made as necessary to produce anticipated loss ratios, including when Medicare's benefits change.

(e) *Renewability, Replacement, and Coverage Continuation; Preexisting Condition and Medical Underwriting Limitations.*—Section 1882 of the Social Security Act contains no provision.

The NAIC standards provide that an insurer may not cancel or nonrenew a Medigap policy for any reason other than nonpayment of premium or material misrepresentation. If a group Medigap policy is terminated by the group policyholder and is not replaced, the insurer must offer certificateholders an individual Medigap policy which either provides for continuation of the benefits contained in the group policy or provides only such benefits as are required to meet the minimum standards. If membership in a group is terminated, the insurer must offer the certificateholder conversion to an individual policy (as described in the preceding sentence) or, at the option of the group policyholder, continuation of coverage under the group policy. If a group Medigap policy is replaced by another group Medigap policy purchased by the same policyholder, the standards require the succeeding insurer to offer coverage to all persons covered under the old group policy on its termination date. Coverage under the new group policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

The NAIC standards prohibit Medigap policies from denying a claim for a preexisting condition for losses incurred more than 6

months from the coverage effective date. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the coverage effective date. The NAIC standards require that if a Medigap policy is replaced by another Medigap policy, the new policy must waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods for similar benefits to the extent such time was spent under the original policy.

(f) Minimum Loss Ratios for Daily Hospital Indemnity and Dread Disease Policies.—Section 1882 of the Social Security Act contains no loss ratio provisions for hospital indemnity and dread disease policies.

The NAIC Guidelines for Filing of Rates for Individual Health Insurance Forms (including individual hospital indemnity and dread disease policies) include minimum loss ratios of 60 percent for optionally renewable policies, 55 percent for conditionally and guaranteed renewable policies, and 50 percent for noncancellable policies. States vary in their requirements for loss ratios for hospital indemnity and dread disease policies.

(g) Enforcement of Standards.—Section 1882 of the Social Security Act includes provisions for the regulation of Medigap policies, including:

- (1) a program of voluntary submission by States of their Medigap regulatory programs for approval by a Supplemental Health Insurance Panel;
- (2) a voluntary certification program of Medigap policies by the Department of Health and Human Services (DHHS); and
- (3) civil and criminal penalties for certain abusive sales practices.

Section 1882 contains certain requirements for Medigap policies; in addition, it incorporates by reference requirements provided in model standards (including law and regulations) approved by the National Association of Insurance Commissioners (NAIC).

The Federal/NAIC Medigap standards are implemented in two ways. States may submit their Medigap regulatory programs for approval to the Supplemental Health Insurance Panel, which consists of the Secretary and 4 State commissioners or superintendents of insurance appointed by the Secretary to the Panel. If such State programs meet or exceed the Federal/NAIC standards, then policies approved in those States are deemed to meet the Federal requirements. In States that do not have approved Medigap regulatory programs, individual insurers may voluntarily submit their policies to the Voluntary Certification Program at HHS to be certified.

Section 1882 also provides civil and criminal penalties for certain abusive sales practices, including making false statements and misrepresentations, falsely claiming to represent any Federal agency in order to sell insurance, selling health insurance policies that substantially duplicate other health benefits, and mailing into a State Medigap policies that have not been approved.

(h) Requiring Approval of State for Sale in the State.—Section 1882 of the Social Security Act provides that a Medigap policy sold through the mail can be considered to be approved in a State if (1)

the policy has been certified by the Secretary or was issued in a State with an approved regulatory program; (2) the policy has been approved by the commissioners of insurance in States in which more than 30 percent of such policies are sold; or (3) the State has in effect a law which the State's commissioner of insurance has determined gives him or her the authority to review and approve, or effectively bar from sale, in the State such a policy. Such a policy would not be deemed to be approved by a State if the State notifies the Secretary that such policy was disapproved by the State after providing appropriate notice and opportunity for hearing according to the procedures (if any) of the State.

(i) Counseling and Education Programs.—Section 1882 of the Social Security Act requires the Secretary to provide to all Medicare beneficiaries (and, to the extent feasible, to prospective beneficiaries) such information as will permit them to evaluate the value of Medigap policies to them and the relationship of Medigap policies to Medicare benefits. The Secretary is required to (1) inform beneficiaries about marketing and sales abuses subject to sanctions under Section 1882 and the manner in which they may report any such action or practice to an appropriate official of HHS or a State, and (2) publish the toll-free telephone number for individuals to report suspected violations of the marketing and sales requirements. The Secretary must also provide Medicare beneficiaries with a listing of the addresses and telephone number of State and Federal agencies and offices that provide information and assistance to individuals about the selection of Medigap policies.

(j) GAO Reports and Studies.—No provision.

(k) Increase in Civil Money Penalties.—Section 1882 of the Social Security Act provides for civil money penalties of not to exceed \$5,000 for violations of the marketing and sales practices provisions.

(l) Premium Increases.—No provision.

(m) Limitations on Certain Sales Commissions.—Section 1882 of the Social Security Act contains no provision.

The NAIC standards provide that first year commissions or other compensation for an agent may not exceed 200 percent of the commission or other compensation for selling or servicing the Medigap policy in the second year. The commission or total compensation in subsequent (renewal) years must be the same as that provided in the second year, and must be provided for a reasonable number of renewal years. Entities are prohibited from providing compensation to agents greater than the renewal compensation payable by the replacing insurer on renewal policies if an existing policy is replaced, unless benefits of the new policy are clearly and substantially greater than benefits under the replaced policy.

(n) Treatment of Plans Offered by Health Maintenance Organizations and Competitive Medical Plans.—No provision.

(o) Additional Enforcement Through Public Health Service Act.—No provision.

(p) Medicare Select Policies.—NAIC Medigap standards specify certain minimum benefit and policy provisions that must be met for a Medigap policy to be approved. These requirements can make it difficult for preferred provider arrangements, which include ben-

efit and cost-sharing variations as incentives for enrollees to seek care with lower-cost preferred providers, to offer Medigap policies.

House bill

(a) *Simplification of Policies.*—In order for a Medigap policy to be certified by the Secretary, requires that such policies meet new simplification standards approved by the NAIC (or, if NAIC does not approve such standards, by the Secretary). (See (g)(4) Promulgation of Regulations, below, for additional information about promulgation of standards.) Such standards must provide for a core group of basic benefits (not including payment of any deductibles), and a group of benefits including the core group and common additional benefits. Provides that the total number of different benefit packages (including the core group, the core plus common benefits, and each other combination of benefits that may be offered as a separate benefit package) cannot exceed 10.

Provides that, to the extent possible, the benefit requirements must include benefits that offer consumers the ability to purchase the benefits available in the market on the date of enactment, and that balance the objectives of simplifying the market to facilitate policy comparisons, avoiding adverse selection, providing consumer choice, providing market stability, and promoting competition.

Authorizes the Secretary, upon application by a State, to waive the simplification standards for a period of up to 3 years in order to demonstrate the offering of new or innovative benefits, including managed care features. Requires the Secretary to evaluate the new or innovative benefits to determine whether they should be added to the NAIC simplification standards. If so, requires the Secretary to request NAIC to modify the standards; if NAIC fails to do so in a timely manner, requires the Secretary to modify the standards. Provides that not more than 3 additional groups of benefits may be added.

Provides that States may restrict the groups of packages of benefits, except for the core group of basic benefits and the core plus common group of benefits.

Provides that Medigap issuers would not be prevented from providing, through arrangements with vendors, for vendor discounts to policyholders to purchase items or services not covered under the Medigap policy.

Requires anyone who sells a Medigap policy to an individual to make available to the individual both a Medigap policy with only the core group of benefits, and a Medigap policy with the core plus common benefits. Provides that violators would be subject to a civil money penalty of not to exceed \$25,000 for each such violation.

(b) *Uniform Policy Description.*—Requires that policy issuers must provide, before the sale of a Medigap policy, a summary information sheet which describes the policy's benefits and premium, and the average loss ratio for the most recent 3-year period (or, for policies not in effect for 3 years, the average loss ratio expected during the third year). Requires that such information be on a standard form approved by the State (in consultation with the Secretary), consistent with the NAIC simplification standards. Provides that violators would be subject to a civil money penalty of not to exceed \$25,000 for each such violation.

Requires that the simplification standards include uniform benefit language and definitions and uniform format to be used in the policy with respect to such benefits.

(c) Prevention of Duplicate Medigap Coverage.—

*(1) Statement Regarding Other Health Benefits Coverage.—*Provides that it would be unlawful for a person to issue or sell a Medigap policy to an individual entitled to Medicare benefits, whether directly, through the mail, or otherwise, unless the person obtains from the individual, as part of the application, a written statement signed by the individual stating what health insurance policies the individual has, from what source, and whether the individual is entitled to Medicaid. Provides that the written statement must be accompanied by a written acknowledgment, signed by the seller, of the request for and receipt of the statement. Provides that the statement must be on a form that includes specified language regarding duplicative benefits and that counseling services may be available in the State.

Provides that it would also be unlawful to sell or issue a Medigap policy to someone whose written statement indicates that they have another Medigap policy or are entitled to Medicaid.

Provides that it would not be unlawful to sell or issue a Medigap policy to an individual who has a Medigap policy but is not entitled to Medicaid, if the individual indicates in writing that the policy replaces the other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective.

Provides that the penalty for violations would be a fine under Title 18, or imprisonment for not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, a civil money penalty of not to exceed \$25,000 for each such violation.

Amends current law to: (A) delete that the Medigap issuer must “knowingly” sell a duplicative policy to be in violation; (B) delete that the duplicative policy must “substantially” duplicate other benefits; (C) include Medicaid benefits as those which cannot be duplicated; (D) increase the penalty for violations from \$5,000 to \$25,000; and (E) authorize persons aggrieved by a violation to recover in a civil action threefold the damages sustained, any other appropriate relief (including punitive damages), and the costs of the suit (including reasonable attorney’s fees).

(2) Suspension of Policies During Receipt of Medicaid Benefits.—

Requires that Medigap policies suspend their benefits and premiums for any period in which the policyholder has applied for and is determined to be entitled to Medicaid, only if the policyholder notifies the Medigap issuer within 90 days after becoming entitled to Medicaid. Provides that if the policyholder loses entitlement to Medicaid, the policy would be automatically reinstated as of the termination of Medicaid entitlement, if the policyholder provides notice within 90 days after the loss of entitlement.

Provides that this provision would not affect the authority of a State to purchase Medigap policies for those entitled to Medicaid.

*(d) Loss Ratio Requirements.—*Amends current law to require that certified Medigap policies or health insurance policies that are indemnity or dread disease policies (as defined by the Secretary in consultation with the NAIC) may not be issued or sold in any State unless the policy has returned (for the most recent 3-year period,

on the basis of incurred claims experience and earned premiums and in accordance with accepted actuarial principles and practices and standards developed by the NAIC) to policyholders in the form of aggregate benefits, loss ratios of a least 75 percent for group Medigap policies, at least 70 percent for individual Medigap policies, and at least 60 percent for group and individual indemnity and dread disease policies.

Requires that policy issuers must annually submit to the State information on actual loss ratios on forms conforming to those developed by the NAIC.

Requires policy issuers to annually provide a proportional credit of the amount of premiums received necessary to assure that the loss ratios (net of any credits) comply with the loss ratio requirements. Provides that such credits would be required for each type of policy by policy number, and would not apply for the first 2 years of a policy. Requests the NAIC to submit to Congress a report containing recommendations on adjustments in the loss ratio percentages that may be appropriate in order to apply the credit requirement to the first 2 years in which policies are in effect. Provides that the credit must include interest from the end of the policy year involved until the date of the credit, at a rate, specified by the Secretary from time to time, that is not less than the average rate of interest for 13-week Treasury notes. Requires that each issuer of a policy subject to the credit requirements would be liable to policyholders for such credits.

Provides that States may require higher loss ratio percentages.

Requires GAO to periodically, not less often than once every 3 years, to perform audits of the compliance of Medigap policies with loss ratio and premium increase requirements, and to report the results to the State involved and to the Secretary. Authorizes the Secretary to independently perform such compliance audits.

Provides that persons who issue policies in violation of the loss ratio and premium increase requirements would be subject to a civil money penalty of not to exceed \$25,000 for each such violation. Provides that certain provisions of Section 1128A would apply to the civil money penalty.

Requires that approved State programs must require that a copy of each Medigap policy, its most recent premium, and its loss ratios for the most recent 3-year period be maintained and made available to interested persons.

Requires that policy issuers provide, before the sale of the policy, a summary information sheet which describes benefits, premiums, and loss ratios for the most recent 3-year period.

(e) Renewability, Replacement, and Coverage Continuation; Preexisting Condition and Medical Underwriting Limitations.—Requires that Medigap policies be guaranteed renewable, and that the issuer may not cancel or nonrenew the policy 1) solely on the ground of the individual's health status, and 2) for any reason other than nonpayment of premium or material misrepresentation.

Requires that if the Medigap policy is terminated by the group policyholder and is not replaced, the issuer must offer certificateholders an individual Medigap policy which (at the option of the certificateholder) provides for continuation of the group policy's benefits, or for such benefits as otherwise meet the requirements of

this section. Provides that if an individual terminates membership in a group through which they have a group Medigap policy, the issuer must 1) offer an opportunity to convert to an individual policy that continues the group policy's benefits or benefits meeting this section's requirements, or 2) at the option of the group policyholder, offer continuation of coverage under the group policy. Provides that if a group Medigap policy is replaced by another group Medigap policy purchased by the same policyholder, the succeeding issuer must offer coverage to all persons covered under the old group policy on its termination date. Prohibits coverage under the new policy from resulting in any exclusion for preexisting conditions that would have been covered under the old group policy.

Requires an entity that issues Medigap policies in a State to offer any individual who is 65 or older and who resides in the State, upon request of the individual during the 6-month period beginning with the first month in which the individual has attained such age and is enrolled in Part B, the opportunity of enrolling in a Medigap policy that provides for a core group of basic benefits and a Medigap policy that provides for a core group and common additional benefits, without conditioning the issuance or effectiveness of such a policy on, and without discriminating in the price of such policy based on, the medical or health status or the receipt of health care by the individual.

Provides that policies may exclude benefits during the first 6 months based on a preexisting condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before it became effective.

Requires that if a Medigap policy replaces another such policy which has been in effect for 6 months or longer, the replacing policy may not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new policy for similar benefits.

(f) Minimum Loss Ratios for Daily Hospital Indemnity and Dread Disease Policies.—Requires that no health insurance policy that is an indemnity or dread disease policy (as defined by the Secretary in consultation with the NAIC) can be issued in any State unless the policy returns (for the most recent 3-year period) a loss ratio of at least 60 percent for both group and individual policies.

(g) Enforcement of Standards.—

(1) Mandatory Conformity with Standards.—Provides that no Medigap policy may be sold, issued, or renewed in any State unless the State's regulatory program provides for the application and enforcement of the Section 1882 standards (including the NAIC simplification standards) by the date specified below, or the Secretary has certified that the policy meets such standards. Provides that any person who issues or sells a Medigap policy, after the effective date of the NAIC simplification standards, in violation would be subject to a civil money penalty of not to exceed \$25,000 for each such violation. Provides that certain provisions of Section 1128A would apply to the civil money penalties.

(2) Certification of State Programs by the Secretary.—Abolishes the Supplemental Health Insurance Panel and provides that the Secretary, rather than the Panel, would approve State regulatory programs. Requires the Secretary periodically to review State regu-

latory programs to determine if they continue to meet the standards. Provides that if the Secretary finds that a State program no longer meets the standards, before making a final determination the Secretary must provide the State an opportunity to adopt a plan of correction that would permit the State to continue to meet the standards. Provides that if the Secretary makes a final determination that the State program, after such an opportunity, fails to meet the standards, the program would no longer be approved.

(3) *State Enforcement*.—Requires that State programs enforce, as well as apply, the NAIC standards.

(4) *Promulgation of Regulations*.—Provides that if, within 9 months of enactment, the NAIC promulgates limits on groups of benefits that may be offered by a Medigap policy (consistent with this bill), uniform benefit language and definitions, uniform benefit format, and transitional requirements as described below (collectively known as the “NAIC simplification standards”), then these standards are to be applied in each State for policies to be approved. Provides that if NAIC does not promulgate such standards, then the Secretary must promulgate such standards, not later than 18 months from enactment.

Provides that approved State programs must apply these standards by the earlier of (A) the date the State adopts the NAIC standards, or (B) 1 year after the NAIC or the Secretary first adopts the standards.

Provides that for States the Secretary identifies, in consultation with the NAIC, as requiring State legislation (other than legislation appropriating funds) to revise the Medigap standards, but the State legislature is not scheduled to meet in 1992, the effective date would be the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1992. For States that have a 2-year legislative session, provides that each year of such session would be deemed to be a separate regular session.

Provides that in promulgating the simplification standards, NAIC or the Secretary must consult with a working group composed of representatives of issuers of Medigap policies, consumer groups, Medicare beneficiaries, and other qualified individuals. Requires that such representatives be selected in a manner to assure balanced representation among the interested groups. Provides that if Medicare benefits (including deductibles and coinsurance) change and the Secretary determines, in consultation with the NAIC, that changes in the simplification standards are needed, then these provisions for modification of the standards would apply to subsequent changes.

Provides transitional requirements for Medigap policies issued before the effective date of the NAIC (or Federal) simplification standards and which do not meet such standards. Provides that any renewal of such policy would be in violation unless the issuer offers to the policyholder, not later than 60 days before the effective date of the renewal, 2 Medigap policies each of which (A) complies with the standards; (B) waives any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the policy for similar benefits to the extent such time was spent under the policy being replaced; and (C) pro-

vides for classification of premiums on terms that are at least as favorable to the policyholder as those applied to the policyholder on the effective date of the standards. Provides that one of the policies must include the core group of basic benefits and the other must include the core group and common additional benefits.

(5) *Disclaimer for Unapproved Policies.*—No provision.

(h) *Requiring Approval of State for Sale in the State.*—Strikes from current law language authorizing alternative methods for approval in a State of Medigap policies sold through the mail, and provides instead that it is illegal to sell Medigap policies that have not been approved by a State with an approved regulatory program or certified by the Secretary.

Provides that nothing in this section should be construed as affecting the right of any State to regulate Medigap policies which are considered to be issued in another State. Increases the maximum civil money penalty for violations from \$5,000 to \$25,000.

(i) *Counseling and Education Programs.*—Requires the Secretary to request the NAIC to establish an educational program to educate consumers on the Medigap simplification standards.

Requires the HHS Secretary to establish a health insurance advisory service program, known as the "beneficiary assistance program," to assist Medicare-eligible individuals with the receipt of services under Medicare, Medicaid, and other health insurance programs. Requires that the beneficiary assistance program must provide assistance 1) through operation using local Federal offices that provide information on the Medicare program, 2) using community outreach programs, and 3) using a toll-free telephone information service. Requires that the beneficiary assistance program provide for information, counseling, and assistance for Medicare-eligible individuals with respect to at least the following:

(1) For Medicare: eligibility; benefits (covered and not covered); process of payment for services; rights and process for appeals of determinations; other Medicare-related entities such as peer review organizations, fiscal intermediaries, and carriers; and recent legislative and administrative changes in the Medicare program.

(2) For Medicaid: eligibility, benefits, and the application process; linkages between the Medicaid and Medicare programs; referral to appropriate State and local agencies involved in the Medicaid program.

(3) For Medigap policies: the program under Section 1882 of the Social Security Act and its standards; how to make informed decisions on whether to purchase such policies and on what criteria to use in evaluating different policies; appropriate Federal, State, and private agencies that provide information and assistance in obtaining benefits under such policies; and other issues deemed appropriate by the Secretary.

Also requires that the beneficiary assistance program provide such other services as the Secretary deems appropriate to increase beneficiary understanding of, and confidence in, the Medicare program and to improve the relationship between beneficiaries and the program.

Requires the Secretary, through the HCFA Administrator, to develop appropriate educational material and other appropriate techniques to assist employees in carrying out this section.

Requires the Secretary to take any necessary steps to assure that Medicare-eligible beneficiaries and the general public are made aware of the beneficiary assistance program.

Requires the Secretary to include, in an annual report to Congress, a report on the beneficiary assistance program and on other health insurance informational and counseling services made available to Medicare-eligible individuals. Requires the Secretary to include in the report recommendations for such changes as may be desirable to improve the relationship between the Medicare program and Medicare-eligible individuals.

(j) *GAO Reports and Studies.*—Requires the Comptroller General to examine the effectiveness of the Medigap simplification program established under this subsection and the impact of the program on consumer protection, health benefit innovation, consumer choice, and health care costs. Requires the Comptroller General, within 4 years of enactment, to report to Congress on this examination, including such recommendations on the appropriate roles of the NAIC, States, and the Secretary in carrying out such program as he/she deems appropriate.

(k) *Increase in Civil Money Penalties.*—Increases civil money penalties from \$5,000 to \$25,000 for false statements of material fact with respect to the compliance of a Medigap policy with the standards, and for mailing a policy into a State for a prohibited purpose.

(l) *Premium Increases.*—Requires that a Medigap policy or a health insurance policy that is an indemnity policy or dread disease policy (as defined by the Secretary in consultation with the NAIC) may not be issued or sold in any State unless any premium increase or the initial establishment of the premium is made as follows. Requires the issuer to submit to the State (at such time as the State specified, but not earlier than 90 days before the proposed effective date), the proposed premium amounts, including information, certified as accurate by an actuary, that establishes that the premium amounts are reasonable in relation to the benefits and that the resulting loss ratio will meet the loss ratio requirements. Provides that these requirements do not preempt a State from requiring the review or approval of premiums not otherwise required by this section or providing additional requirements for the approval of premiums.

(m) *Limitations on Certain Sales Commissions.*—Provides that it is unlawful for a person who provides for a commission or other compensation to an agent or other representative for the sale of a Medigap policies to provide 1) a first year commission or other first year compensation that exceeds 200 percent of the commission or other compensation for selling or servicing of the policy in a second or subsequent year, or 2) for compensation with respect to replacement of such a policy that is greater than the compensation that would apply to the renewal of the policy. Defines "compensation" to include pecuniary and nonpecuniary compensation of any kind relating to the sale or renewal of a policy and specifically includes bonuses, gifts, prizes, awards, and finders' fees.

Provides that violators would be fined under Title 18, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, would be subject to a civil money penalty of not to exceed \$25,000 for each violation.

(n) *Treatment of Plans Offered by Health Maintenance Organizations and Competitive Medical Plans.*—Provides that the definition of a Medigap policy under Section 1882 of the Social Security Act would not include a policy or plan of an HMO or other direct service organization that offers benefits under Medicare, including services under a contract under Section 1833 or Section 1876.

(o) *Additional Enforcement Through Public Health Service Act.*—Provides that a person who fails to meet the requirements of Section 1882(o)(5) of the Social Security Act as added by this bill (relating to discriminatory practices in the sale of Medigap policies, such as preexisting condition limitations and limitations on medical underwriting) would be subject to a civil money penalty of not to exceed \$25,000 for each such violation. Provides that certain sections of Section 1128A of the Social Security Act would apply to the civil money penalty.

Provides that a person who issues or sells a Medigap policy or a health insurance policy that is an indemnity or dread disease policy (as defined by the HHS Secretary) in violation of Section 1882(q)(1) as added by this bill (relating to loss ratios and premium increases) would be subject to a civil money penalty of not to exceed \$25,000 for each such violation. Provides that certain sections of Section 1128A of the Social Security Act would apply to the civil money penalty.

Provides that whoever violates Section 1882(o)(5)(A) of the Social Security Act as added by this bill (relating to sales commissions) would be fined under Title 18, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, would be subject to a civil money penalty of not to exceed \$25,000 for each prohibited act.

(p) *Medicare Select Policies.*—No provision.

Effective date: Enactment, except (c), (d) (f) and (l) apply to policies issued or sold more than 1 year after enactment; portions of (e) related to preexisting conditions and medical underwriting apply 1 year after enactment; (h) applies to policies mailed, or caused to be mailed, on and after July 1, 1991; and (n) applies to compensation provided on or after 1 year after enactment.

Senate amendment

(a) *Simplification of Policies.*—In order for a Medigap policy to be certified by the Secretary, requires that such policies meet new simplification standards approved by the NAIC (or, if NAIC does not approve such standards, by the Secretary). (See (g)(4) Promulgation of Regulations, below, for additional information about promulgation of standards.) Provides that such standards must provide for 1) groups of basic benefits, or additional, optional benefits, as may be appropriate; 2) identification of a core group of basic benefits that includes only the minimum benefits required of Medigap policies on the date of enactment, not including payment of any deductible; and 3) if the simplification standards provide for Medigap benefits to be offered as A) a core group of basic benefits plus a defined list of optional additional benefits, or B) through defined benefit packages or policies, then the total number of defined optional additional benefits or different benefit packages (counting the core group) cannot exceed 10; if the simplification standards provide for

Medigap benefits to be offered through defined benefits that the insurer packages as it deems appropriate, then the total number of packages offered by an insurer cannot exceed 4, and the total number of benefits to be packaged may not exceed 10.

Provides that, to the extent possible, the benefit requirements must include benefits that offer consumers the ability to purchase the benefits available in the market on the date of enactment, and that balance the objectives of simplifying the market to facilitate direct comparison of policy prices and benefits, avoiding adverse selection, providing consumer choice, and promoting market stability.

Prohibits a State with an approved regulatory program from permitting the grouping of benefits unless the grouping meets the simplification standards. Authorizes the State, upon application by an insurer, to waive the simplification standards to permit the issuance and sale of a Medigap policy in order to demonstrate the offering of new or innovative benefits. Provides that any such new or innovative benefits must be offered in a manner as approved by the State which is consistent and practically achievable under the simplification standards. Provides that new or innovative benefits may include benefits that are not otherwise available and are cost-effective.

Provides that States may restrict the groups of benefits that may be offered in Medigap policies in the State, but a State with an approved program may not restrict the offering of a Medigap policy consisting only of the core group of benefits.

Requires that if a Medigap policy provides for a group of benefits other than the core group of basic benefits, the policy issuer must make available to the individual a Medigap policy with only the core group of benefits.

(b) Uniform Policy Description.—Requires that policy issuers must provide, before the sale of a Medigap policy, a summary information sheet which describes the policy's benefits (including any optional benefits) and the average loss ratio for the most recent 3-year period (or, for policies not in effect for 3 years, the average loss ratio expected during the third year), and which allows a direct comparison of benefits and prices among policies.

Requires that the simplification standards include uniform benefit language and format to be used with respect to the benefits.

(c) Prevention of Duplicate Medigap Coverage.—

(1) Statement Regarding Other Health Benefits Coverage.—Provides that it would be unlawful for a person to issue or sell a Medigap policy to an individual entitled to Medicare benefits, whether directly, through the mail, or otherwise, unless the person obtains from the individual, as part of the application, a written statement signed by the individual stating what Medigap policies the individual has, from what source, and whether the individual has applied for and been determined to be entitled to Medicaid. Provides that the written statement must be accompanied by a written acknowledgment, signed by the seller, of the request for and receipt of the statement. Provides that the written acknowledgment does not constitute verification or affirmation by the seller of the truth of any information supplied by the individual in the written statement.

Provides that the written statement must be on a form that states that a Medicare beneficiary does not need more than 1 Medi-

gap policy; states that individuals aged 65 or older may be eligible for benefits under the Medicaid program, that such individuals usually do not need a Medigap policy, and that benefits and premiums under any Medigap policy would be suspended upon request of the policyholder when entitled to Medicaid; and includes the toll-free telephone number established by the Secretary under new Section 1889, the address and local telephone number of any counseling program offered by or with the assistance of the State under Medicaid, the State insurance department, or a State agency on aging for individuals considering purchase of a Medigap policy, and the address and local telephone number of the State Medicaid office.

Provides that it would also be unlawful to sell or issue a Medigap policy to someone whose written statement indicates that they have another Medigap policy or are entitled to Medicaid.

Provides that it would not be unlawful to sell or issue a Medigap policy to an individual who has another Medigap policy if (A) the individual indicates in writing that the policy replaces the other policy and indicates an intent to terminate the policy being replaced when the new policy becomes effective; (B) the seller certifies in writing that such policy will not, to the best of the seller's knowledge, duplicate coverage (taking into account any such replacement); and (C) a State Medicaid plan pays the premiums for the Medigap policy or pays less than an individual's full liability for Medicare cost sharing.

Provides that the penalty for violations would be a fine under Title 18, or imprisonment for not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, a civil money penalty of not to exceed \$25,000 for each such violation.

Amends current law to: (A) delete that the Medigap issuer must "knowingly" sell a duplicative policy to be in violation; (B) delete that the duplicative policy must "substantially" duplicate other benefits; (C) include Medicaid benefits as those which cannot be duplicated; and (D) increase the penalty for violations from \$5,000 to \$25,000.

(2) Suspension of Policies During Receipt of Medicaid Benefits.—Requires that Medigap policies suspend their benefits and premiums at the request of the policyholder for any period in which the policyholder indicates that they have applied for and been determined to be entitled to Medicaid. Provides that if the policyholder loses entitlement to Medicaid, the policy would be automatically reinstated as of the termination of Medicaid entitlement, if the policyholder provides notice within 90 days after the loss of entitlement.

(d) Loss Ratio Requirements.—Amends current law to require that certified Medigap policies or health insurance policies may not be issued or sold in any State unless the policy can be expected to return (as estimated for the entire period for which rates are computed, on the basis of incurred claims experience and earned premiums and in accordance with accepted actuarial principles and practices and standards developed by the NAIC) to policyholders in the form of aggregate benefits, loss ratios of at least 75 percent for group policies and at least 65 percent for individual policies. Provides that policies issued as a result of solicitations of individuals

tion appropriating funds) in order for Medigap policies to meet the simplification standards, but the State legislature is not scheduled to meet in 1991, the effective date would be the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1991. For States that have a 2-year legislative session, provides that each year of such session would be deemed to be a separate regular session.

Provides that in promulgating the simplification standards, the NAIC or the Secretary must consult with a working group composed of representatives of issuers of Medigap policies, consumer groups, Medicare beneficiaries, and other qualified individuals. Requires that such representatives be selected in a manner to assure balanced representation among the interested groups.

Provides that every 3 years the Secretary, in consultation with the NAIC, must evaluate the appropriateness of new or innovative benefits and determine whether the incorporation of such benefits into the simplification standards would further the purposes of such standards. If within 90 days after a request from the Secretary the NAIC makes a determination that modification of the NAIC simplification standards is appropriate and modifies the standards to include the additional group of benefits (including accompanying language and format), provides that such modified standards would be applied in each State. If the NAIC does not make such a determination, authorizes the Secretary to make such a determination and modify the simplification standards.

Provides that approved State programs must apply these standards modified to include additional benefits by the earlier of A) the date the State adopts the modified NAIC or Federal simplification standards, or B) 1 year after the NAIC or the Secretary first adopts the modified standards. Provides that for States the Secretary identifies, in consultation with the NAIC, as requiring State legislation (other than legislation appropriating funds) in order for Medigap policies to meet the simplification standards, but the State legislature is not scheduled to meet within the 1-year period after the NAIC or the Secretary adopts the modified standards, the effective date would be the first day of the first calendar quarter after the close of the first legislative session of the State legislature that begins after the date the NAIC or the Secretary adopts the modified standards. For States having a 2-year legislative session, provides that each year of such session would be deemed to be a separate regular session.

Provides that if Medicare benefits are changed and the Secretary determines, in consultation with the NAIC, that changes in the simplification standards are needed, then these provisions for modification of the standards would apply.

Provides transitional requirements that the simplification standards would not apply to Medigap policies issued to a policyholder before the effective date of the NAIC (or Federal) simplification standards.

Authorizes the Secretary to waive the application of simplification standards in those States that on the date of enactment have in place an alternative simplification program.

Requires the Secretary, within 2 years of enactment, to report to Congress on the adoption of the Medigap standards and requirements in this bill, including the identification of States that do and do not have regulatory programs that meet the requirements of this bill, and the reasons for the failure of any States to adopt some or all of the standards.

(5) Disclaimer for Unapproved Policies.—Requires that if an insurer issues a Medigap policy in a State without an approved regulatory program and which the Secretary has determined does not provide consumer protection as great as would be offered under an approved program, and if the policy has not been certified by the Secretary, the insurer must A) prominently display in at least 12 point type on any advertisement for that policy, on each page of the outline of coverage, and on the first page of the policy the following statement: "This policy has not been certified by the Secretary of the United States Department of Health and Human Services as meeting Federal requirements for medicare supplemental policies;" and B) require the purchaser to sign the following statement: "I understand that this policy has not been certified by the Secretary of the United States Department of Health and Human Services as meeting Federal requirements for Medicare supplemental policies."

Provides that insurers violating these requirements would be subject to a civil monetary penalty not to exceed \$25,000 for each violation.

(h) Requiring Approval of State for Sale in the State.—Strikes from current law language authorizing alternative methods for approval in a State of Medigap policies sold through the mail, providing that sale would be prohibited unless the policy has been approved by the State insurance commissioner.

(i) Counseling and Education Programs.—Requires the Secretary to make grants to qualified States to provide information, counseling and assistance relating to the procurement of adequate and appropriate health insurance coverage for Medicare beneficiaries. Authorizes the Secretary to prescribe regulations to establish a minimum level of funding for such grants. Requires States applying for a grant to submit a plan for the program that would (1) establish or improve on a program that includes information about obtaining benefits and filing claims under Medicare and Medicaid, Medigap policy comparison information and information for filing Medigap claims, information regarding long-term care insurance, and information on other types of health insurance benefits the Secretary determines is appropriate; (2) establish a system of referral to appropriate Federal or State agencies for assistance with health insurance coverage problems, including legal problems; (3) provide for sufficient staff (including volunteers); (4) provide assurances that staff have no conflict of interest; (5) provide for the collection and dissemination of timely health care information to staff and regular staff meetings and continuing education programs; (6) provide for training programs for staff; (7) provide for the coordination of the exchange of information between State government staffs and staff of the program; (8) make recommendations concerning consumer issues and complaints to State and Federal health insurance agencies; (9) establish an outreach program to provide health

insurance information, counseling and assistance; and (10) demonstrate, to the satisfaction of the Secretary, an ability to provide the required counseling and assistance.

Provides that States with existing programs must, in order to receive a grant, demonstrate that they will maintain activities of the program at least at the level immediately prior to the issuance of the grant. Provides that if an existing program is substantially similar to that required in order to receive a grant, the Secretary may waive some or all of the requirements and issue a grant to increase the number of services offered by the program, experiment with new methods of outreach, or expand the program to geographic areas of the State not previously served.

Requires the Secretary to consider the following in issuing a grant: (1) the commitment of the State, including the level of cooperation demonstrated by the office of the chief insurance regulator, other officials who oversee insurance plans issued by nonprofit hospital and medical service associations, State agencies administering Medicaid funds and those appropriated under the Older Americans Act; (2) the population of eligible individuals in the State as a percentage of the State's population; and (3) the relative costs and special problems with providing health care information, counseling, and assistance to the rural areas of the State.

Requires States that receive grants to issue an annual report to the Secretary, within 180 days of receiving the grant and annually thereafter, concerning (1) the number of individuals served; (2) an estimate of the amount of funds saved by the State and by eligible individuals in the State; and (3) problems eligible individuals encounter in procuring health care coverage.

Within 180 days of enactment, and annually thereafter, requires the Secretary to issue a report to the Committees on Finance, Aging (House and Senate), Ways and Means, and Energy and Commerce that (1) summarizes the allocation and expenditure of the grant funds; (2) summarizes the scope and content of training conferences; (3) outlines problems that eligible individual encounter in procuring health care coverage; (4) makes recommendations to address problems of procuring coverage; (5) evaluates the effectiveness of the programs and makes recommendations regarding continued authorization of funds (for the report issued 2 years after enactment).

Authorizes appropriations of \$10 million for each of fiscal years 1991 through 1993 in equal parts from the HI and SMI trust funds for such grants.

Adds a new Section 1889 to the Social Security Act requiring the Secretary to provide information via a toll-free telephone number on Medicare's programs and on Medigap policies, including the relationship of Medicaid programs to Medigap policies. Authorizes the Secretary to conduct demonstration projects in up to 5 States to establish statewide toll-free telephone numbers for providing information on Medicare benefits, Medigap policies available in the State, and Medicaid benefits.

(j) GAO Reports and Studies.—Requires the Comptroller General, within 4 years of enactment, to report to Congress describing the impact of the simplification program on consumer protection, health benefit innovation and value of innovative benefits, con-

sumer choice, and health care costs, and including such recommendations on the appropriate roles of the NAIC, States, and the Secretary in carrying out such a program as he/she deems appropriate.

(k) *Increase in Civil Money Penalties.*—Increases civil money penalties from \$5,000 to \$25,000 for false statements of material fact with respect to the compliance of a Medigap policy with the standards, and for mailing a policy into a State for a prohibited purpose.

(l) *Premium Increases.*—Provides that approved State programs must provide for a process for approving or disapproving proposed Medigap premium increases and must establish a policy for the holding of public hearings prior to approval of a premium increase.

(m) *Limitations on Certain Sales Commissions.*—No provision.

(n) *Treatment of Plans Offered by Health Maintenance Organizations.*—Provides that the definition of a Medigap policy under Section 1882 of the Social Security Act does not include any such policy or plan under a contract under Section 1876.

(o) *Additional Enforcement Through Public Health Service Act.*—No provision.

(p) *Medicare Select Policies.*—Provides that if a policy meets the NAIC Model Standards except that its benefits are restricted to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities), the policy would be treated as meeting the standards if:

(1) full benefits are provided for items and services furnished through a network of entities that have entered into contracts with the policy issuer;

(2) full benefits are provided for items and services furnished by other entities if the services are medically necessary and immediately required because of an unforeseen illness, injury, or condition, and it is not reasonable given the circumstances to obtain the services through the network;

(3) the network offers sufficient access; and

(4) the issuer of the policy has an arrangement for an ongoing quality assurance program for items and services furnished through the network.

Requires that approved State Medigap regulatory programs must provide for the application of the above requirements in the case of policies that meet the NAIC standards except that the benefits are limited to items and services furnished by certain entities (or reduced benefits are provided when items or services are furnished by other entities).

Authorizes the Secretary to enter into a contract with an entity whose policy has been certified under new subsection (r) or has been approved by a State under similar requirements to determine whether items and services (furnished to individuals entitled to Medicare benefits and benefits under that policy) are not allowable under Medicare's definitions of items and services considered reasonable and necessary. Provides that payments to the entity must be in such amounts as the Secretary may determine, taking into account estimated savings under contracts with carriers and fiscal intermediaries and other factors the Secretary finds appropriate. Certain Social Security Act requirements related to the use of carriers to administer Medicare benefits and review by peer review organizations would apply to the entity.

Effective date: Enactment, except (d) and (f) apply to policies sold or issued more than 1 year after enactment; and (h) applies to policies mailed, or caused to be mailed, on and after July 1, 1991.

5. *Changes in Medigap Standards*

Conference agreement

(a) *Simplification of Policies.*—The conference agreement includes the House bill, with amendments as follows:

(1) the simplification standards must provide for groups of benefits that include a core group of benefits plus up to 9 other groups of benefits packages;

(2) all insurers must offer the core group of benefits;

(3) new or innovative benefits could be offered in addition to the core group or other specified group of benefits if approved by the State (for a policy issued in a State with an approved program) or by the Secretary (for any other policy), if the policy otherwise complies with the simplification standards;

(4) there would a civil money penalty of not to exceed \$25,000 for noncompliance with the simplification standards;

(5) the Secretary would waive the application of the simplification standards with regard to the limits on benefits in States with alternative simplification programs on the date of enactment;

(6) the simplification standards would apply to new policies issued after the State adopts the standards; insurers would not be required to offer new policies meeting the simplification standards to individuals renewing their Medigap policies;

(7) the Secretary would review the simplification standards after 3 years to determine if changes are necessary to accommodate new benefits.

(b) *Uniform Policy Description.*—The conference agreement includes the House bill, with an amendment that would require the outline of coverage's contents to be specified by the National Association of Insurance Commissioners.

(c) *Prevention of Duplicate Medigap Coverage.*—

(1) *Statement Regarding Other Health Benefits Coverage.*—The conference agreement includes the Senate amendment, with amendments as follows. Civil money penalties of \$15,000 for sellers (i.e., agents) and \$25,000 for issuers (i.e., companies) would be imposed for failing to obtain the written statement concerning duplication or selling a policy to an individual who indicates on the written statement that they have another Medigap policy or that they are entitled to Medicaid. Agents would not be held liable for noncompliance if the written statement is signed, answered completely, and reflects nonduplication. In addition to other requirements, the statement must also indicate that counseling services may be available in the State and may provide the telephone number for such services.

(2) *Suspension of Policies During Receipt of Medicaid Benefits.*—The conference agreement includes the Senate amendment, with

an amendment that the period of suspension of the Medigap policy not exceed 24 months.

(d) *Loss Ratio Requirements.*—The conference agreement includes the Senate amendment, with amendments as follows. Non-compliant companies that fail to issue rebates/credits would be subject to civil money penalties under Title XVIII. Loss ratios must be calculated in accordance with a uniform methodology, including uniform reporting standards, specified by the NAIC. States would be required to report annually to the Secretary on Medigap loss ratios and the use of sanctions for policies that fail to meet the loss ratio standards. The Secretary would be required to submit in February of each year (beginning with 1993) a report to the Committees on Energy and Commerce, Ways and Means, and Finance on loss ratios of Medigap policies and the use of sanctions, including a list of the policies that failed to comply with the loss ratio requirements. Sale of a Medigap policy in violation of the loss ratio standards would be subject to a civil money penalty of not to exceed \$25,000 for each violation.

(e) *Renewability, Replacement, and Coverage Continuation; Preexisting Condition and Medical Underwriting Limitations.*—The conference agreement includes the House bill regarding the requirement that Medigap policies be guaranteed renewable. The conference agreement includes the House bill regarding the prohibition of medical underwriting for 6 months after an individual becomes entitled to Part B, and may not condition the issuance or effectiveness of the policy, or discriminate in the price of the policy, on the medical or health status or the receipt of health care by the individual.

(f) *Minimum Loss Ratios for Daily Hospital Indemnity and Dread Disease Policies.*—The conference agreement does not include the House bill.

(g) *Enforcement of Standards.*—

(1) *Mandatory Conformity with Standards.*—The conference agreement includes the House bill, providing that no Medigap policy may be sold or issued unless the policy either is sold or issued in a State with an approved regulatory program, or has been certified by the Secretary.

(2) *Certification of State Programs by the Secretary.*—The conference agreement includes the House bill, which provides for the period review of State regulatory programs by the Secretary.

(3) *State Enforcement.*—The conference agreement includes the Senate amendment.

(4) *Promulgation of Regulations.*—The conference agreement includes the House bill.

(5) *Disclaimer for Unapproved Policies.*—The conference agreement does not include the Senate amendment.

(h) *Requiring Approval of State for Sale in the State.*—The conference agreement includes the Senate amendment.

(i) *Counseling and Education Programs.*—The conference agreement includes the House bill and the Senate amendment regarding health insurance information, counseling, and assistance grants; a health insurance advisory service program; and the Medicare and Medigap toll-free telephone number, with an amendment that only States with approved Medigap regulatory programs would be eligi-

ble to receive health insurance information, counseling, and assistance grants.

The conferees direct the Secretary of Health and Human Services to build on existing health insurance advisory service programs for Medicare beneficiaries and require such programs to provide information, counseling and assistance regarding Medicare, Medicaid, and Medigap policies. The conferees intend that the Health Care Financing Administration be responsible for providing these advisory services, pending available resources.

(j) *GAO Reports and Studies.*—The conference agreement includes the House bill, with an amendment requiring the GAO to study and report on loss ratios, insurance products similar to Medigap, duplicate health coverage for Medicare beneficiaries with retiree health coverage, medical underwriting in Medigap policies, and the impact of higher loss ratios that States may establish.

(k) *Increase in Civil Money Penalties.*—The conference agreement includes the Senate amendment.

(l) *Premium Increases.*—The conference agreement includes the Senate amendment.

(m) *Limitations on Certain Sales Commissions.*—The conference agreement does not include the House bill. The conferees intend that the NAIC, in promulgating changes in the Model Medigap Regulations to reflect this act, shall delete all after the word “unless” in Section 12(C) of its Model Regulation adopted in December 1989, and in Section 12(D) shall broaden the definition of “open compensation” to include acquisition costs where appropriate and advances and deferred compensation.

(n) *Treatment of Plans Offered by Health Maintenance Organizations and Competitive Medical Plans.*—The conference agreement includes the House bill with an amendment to exempt Section 1876 risk and cost contracts. The amendment also includes a time-limited exemption for Section 1833 cost contracts. The conferees understand that in certain situations Medicare beneficiaries enrolled in Section 1833 contracts are provided comprehensive health benefits at a reasonable price. However, because of the possibility of differences between Section 1833 cost and Section 1876 risk and cost contracts, the conferees instruct the Secretary to review conditions under which Section 1833 cost contractors are required to provide or arrange for all Part B items and services, the extent to which beneficiaries are accorded access to a grievance procedure and Secretarial review of marketing materials, and circumstances under which beneficiaries may enroll in Section 1833 cost controls. The conferees also expect the Secretary to review Medicare Parts A and B costs of beneficiaries enrolled in Section 1833 cost contracts compared to beneficiaries not enrolled in such contracts. The conferees expect this report along with recommendations will be submitted to the Committees on Finance, Ways and Means, and Energy and Commerce by July 1, 1991. Upon submission of the Secretary’s study and recommendations, the conferees expect Congress to consider modifying the time-limited exemption for Section 1833 contracts.

(o) *Additional Enforcement Through Public Health Service Act.*—The conference agreement does not include the House bill.

(p) *Medicare Select Policies.*—The conference agreement includes the Senate amendment, with an amendment that the Medicare select provisions would be applied in a 15-State demonstration, conducted for 3 years (1992-1995).

6. *Peer Review Organization Amendments.*—(Section 4101-4106 of the House bill, section 6154 of the Senate amendment)

Present Law

(a) *Use of Corrective Action Plans.*—Peer Review Organizations (PROs) review the appropriateness, reasonableness and medical necessity, and quality of care provided to Medicare patients. If, after reasonable notice, a PRO determines that a practitioner has either failed to comply with program obligations in a substantial number of cases, or has grossly and flagrantly violated these obligations, the PRO is required to refer the case to the Secretary. The Secretary may, in addition to other sanctions, exclude the practitioner from the Medicare program if the Secretary finds that the practitioner has demonstrated an unwillingness or lack of ability substantially to comply with program obligations.

(b) *Optometrists and Podiatrists.*—The Omnibus Budget Reconciliation Act (OBRA) of 1989 required PROs to establish procedures for involving non-physicians in the review of services within their own profession.

Existing law permits only physicians, osteopaths and, for dental surgery, dentists to be utilized in making final determinations of PRO payment denials.

PROs are required to utilize the services of practitioners of, or specialists in, the various types of medicine (including dentistry), or other types of health care in reviewing services provided by practitioners or specialists in the same profession.

(c) *Exchange of Information with State Licensing Boards.*—Current law requires each PRO to collect information relevant to its functions, to keep and maintain such records in such form as the Secretary may require, and to permit access to and use of any such information and records as the Secretary may require to carry out PRO responsibilities, subject to the provision of the law relating to prohibition on information disclosure. This provision limits the circumstances under which, and to whom, a PRO may disclose information obtained in the course of its activities relating to the review of Medicare services. The PRO is required, at the request of a State licensing board, to release information relating to a specific case, but only to the extent that such data and information are required by that board to carry out its responsibilities.

(d) *Coordination of PROs and Carriers.*—Current law requires that a PRO notify the Medicare carrier whenever it makes a determination that Medicare payment should be denied for services furnished to a patient. It also requires that each PRO coordinate activities, including information exchanges, which are consistent with the economical and efficient operation of programs among appropriate public and private agencies, including Medicare carriers. There is no requirement that the Secretary provide for a study of PRO coordination with Medicare carriers. Current law requires that if a Medicare carrier makes determinations or payments with

respect to physicians' services, that the carrier implement specified programs.

(e) *Confidentiality of Peer Review.*—Current law provides that no patient record in possession of a PRO can be subject to subpoena or discovery proceedings in a civil action.

(f) *Role of PROs in Review of Hospital Transfers.*—Section 1867 of the Social Security Act requires hospitals as a condition of Medicare participation, to comply to the extent applicable with requirements relating to the examination and treatment for emergency medical conditions and women in active labor. These provisions are sometimes referred to as the "hospital patient protection" or "anti-dumping" provisions.

Section 1154 of the Social Security Act specifies the functions of the Peer Review Organizations. It provides, in general, that any utilization and quality control peer review organization entering into a contract with the Secretary must review specified professional services to determine whether they are reasonable and medically necessary; whether the quality of such services meets professionally recognized standards of health care; and whether or not the services are provided in an appropriate setting. There is no current requirement that PROs review sanction recommendations under the patient protection provisions (section 1867) of the Social Security Act.

(g) *Notice to State Medical Boards when Adverse Actions are Taken.*—Peer Review Organizations (PROs) review the appropriateness, reasonableness and medical necessity, and quality of care provided to Medicare patients. If, after reasonable notice, a PRO determines that a practitioner has either failed to comply with program obligations in a substantial number of cases, or has grossly and flagrantly violated these obligations, the PRO is required to refer the case to the Secretary. The Secretary may, in addition to other sanctions, exclude the practitioner from the Medicare program if the Secretary finds that the practitioner has demonstrated an unwillingness or lack of ability substantially to comply with program obligations.

(h) *Clarification of Limitation on Liability.*—Current law extends immunity from criminal or civil liability to any person employed by, or who has a fiduciary relationship with, or who furnishes professional services to a PRO, provided that he or she has exercised due care in performing duties under the PRO law.

House bill

(a) *Use of Corrective Action Plans.*—No provision.

(b) *Optometrists and Podiatrists.*—Amends the statute to provide that in addition to doctors of medicine, osteopathy and dentistry, PROs may use doctors of podiatry and optometry in making final payment denial determinations.

Requires that, to the extent necessary and appropriate, PROs utilize the services of practitioners of, or specialists in, the various types of medicine (including dentistry, optometrists and podiatrists) or other types of health care.

(c) *Exchange of Information with State Licensing Boards.*—Amends the Social Security Act relating to PRO functions to require that each PRO notify the State boards or boards responsible

for the licensing or disciplining of any physician when the PRO submits a report and recommendations to the Secretary with respect to sanctioning a physician who has been determined by the PRO to have failed in a substantial number of cases to comply with his or her obligations or to have grossly and flagrantly violated any such obligation.

Amends the Social Security Act relating to the prohibition of disclosure of information by the PROs. Require that each PRO provide notice to the State medical board when the PRO submits a sanctions report and recommendations to the Secretary with respect to a physician for whom the board is responsible for licensing.

(d) *Coordination of PROs and Carriers.*—Amends the Medicare law to require that in carrying out coordinating activities with carriers and other entities, as may be appropriate, that each PRO provide in a manner specified by the Secretary for: (1) information exchange in accordance with specifications of the Secretary; (2) development of common utilization and quality review claim edits and specific medical review criteria used to identify individual claims for review; and (3) collaboration on the analysis of utilization trends and on the results of medical reviews and collaboration on the development of claim edit standards and review criteria. Amends the law relating to Medicare carriers to require that carriers coordinate their activities with those of PROs, in the manner specified by the Secretary, to carry out the coordination activities specified above. Requires the Secretary to report by January 1, 1992 to the House Committees on Ways and Means and Energy and Commerce and the Senate Finance Committee on the implementation of the amendments made by this section.

(e) *Confidentiality of Peer Review.*—Amends current law to provide that no document or other information produced by a PRO in connection with its deliberations in making quality determinations is subject to subpoena or delivery in any administrative or civil proceeding except that a PRO is required to provide, upon request of a practitioner or other person adversely affected by such PRO's quality determination, a summary of the PRO's findings and conclusions in making such a determination.

(f) *Role of PROs in Review of Hospital Transfers.*—Requires the consultation of the Secretary with PROs with respect to allegations of violations of the provisions of requirements of section 1867 of the Social Security Act relating to the examination and treatment of emergency medical conditions and women in labor.

(1) In General: Requires the Secretary to require the appropriate PRO to review the medical condition of the individual and provide a report concerning its findings and professional opinions with respect to certain concerns. Specifies these concerns to be: (1) whether the individual had an emergency medical condition which had not been stabilized, and (2) if the individual was transferred, whether, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweighed the increased risks to the individual (and, in the case of labor, to the unborn child) from effecting the transfer, and whether the transfer was an appropriate transfer (as defined under the

law). Requires, except in the case in which a delay would immediately jeopardize the health or safety of individuals, that the Secretary request such a review before terminating or suspending the provider from Medicare or imposing civil monetary penalties and to provide for at least 60 days for the review. (2) *Conforming Amendments:* Amends the PRO provisions of the Social Security Act by requiring each PRO to provide for a review and report to the Secretary as stated under the patient protection provisions of the law. Requires the PRO to provide reasonable notice of the review to the physician and hospital involved. Requires that within the time period permitted by the Secretary, the PRO must provide a reasonable opportunity for discussion with the physician and hospital involved, and an opportunity for the physician and hospital to submit additional information, before issuing its report to the Secretary.

(g) *Notice to State Medical Boards when Adverse Actions are Taken.*—Amends the law relating to PRO sanctions to require the Secretary to notify the State board responsible for the licensing of the physician when the Secretary effects an exclusion of the physician from the Medicare program.

(h) *Clarification of Limitation on Liability.*—No provision.

Effective date: (a) no provision; (b) applies to contracts entered into or renewed on or after enactment; (c) applies to notices of proposed sanctions issued more than 60 days after enactment; (d) enactment; (e) applies to all proceedings as of enactment; (f) subsection (1) applies on the first day of the first month beginning more than 60 days after enactment; subsection (2) applies to contracts as of the first day of the first month beginning more than 60 days after enactment; (g) applies to sanctions effected more than 60 days after enactment; (h) no provision.

Senate amendment

(a) *Use of Corrective Action Plans.*—Provides that before a PRO submits its report and recommendations to the Secretary, the PRO may provide the practitioner or person with the opportunity to enter into and complete a corrective action plan (which may include remedial education) if appropriate. Provides that in determining whether a practitioner or person has demonstrated an unwillingness or lack of ability substantially to comply with their obligations, the Secretary is required to consider the practitioner's or person's unwillingness or lack of ability, during the period before the PRO submits its recommendations, to enter into and successfully complete a corrective action plan.

(b) *Optometrists and Podiatrists.*—Similar to section 4106 but uses the term podiatric medicine instead of podiatry.

(c) *Exchange of Information with State Licensing Boards.*—No provision.

(d) *Coordination of PROs and Carriers.*—No provision.

(e) *Confidentiality of Peer Review.*—No provision.

(f) *Role of PROs in Review of Hospital Transfers.* No provision.

(g) *Notice to State Medical Boards when Adverse Actions are Taken.* No provision.

(h) *Clarification of Limitation on Liability.*—Clarifies that PROs are also included in the limitation on liability and provides

that the limitation on liability is extended provided that due care was exercised in the performance of such duty, function, or activity (as provided under the law).

Effective date: (a) applies to initial determinations made by PROs on or after January 1, 1991; (b) applies to contracts entered into on or after enactment; (c) no provision; (d) no provision; (e) no provision; (f) no provision; (g) no provision; (h) enactment.

Conference agreement

6. Provisions Relating to Peer Review Organizations

(a) *Use of Corrective Action Plans.*—The conference agreement includes the Senate amendment. The provision applies to initial determinations made by PROs on or after the date of enactment.

(b) *Optometrists and Podiatrists.*—The conference agreement includes the Senate amendment.

(c) *Exchange of Information with State Licensing Boards.*—The conference agreement includes the House bill with a modification to provide that if the PRO finds, after notice and hearing, that a physician has furnished services in violation of this subsection, the PRO is required to notify the State board or boards responsible for the licensing or disciplining of the physician of its finding and decision.

(d) *Coordination of PROs and Carriers.*—The conference agreement includes the House bill with modifications to require that the Secretary develop a plan to coordinate the physician review activities of PROs and carriers. The plan is required to include (A) the development of common utilization and medical review criteria; (B) criteria for the targetting of reviews by PROs and carriers; and (C) improved methods for exchange of information among PROs and carriers. The conference agreement requires the Secretary to submit to Congress a report on the development of the plan and to include in the report such recommendations for changes in legislation as may be appropriate.

(e) *Confidentiality of Peer Review.*—The conference agreement includes the House bill.

(f) *Role of PROs in Review of Hospital Transfers.*—See the provision amending Medicare Parts A and B related to Hospital Transfers.

(g) *Notice to State Medical Boards when Adverse Actions are Taken.*—The conference agreement includes the House bill.

(h) *Clarification of Limitation on Liability.*—The conference agreement includes the Senate amendment.

The conference agreement also includes miscellaneous technical amendments relating to patient notification requirements and clarification of applications of criteria for denial of payments.

7. Miscellaneous and Technical Provisions Relating to Parts A and B

Present law

(a) *Extension of Expiring Provisions.*—

(1) *Prohibition on Payment Cycle Changes.*—Under OBRA of 1987 (P.L. 100-203), the Secretary is prohibited from issuing any final

regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down Medicare claims processing or delaying the rate at which claims are paid. The provision expires September 30, 1990.

(2) *Waiver of Liability for Home Health Agencies.*—When a provider furnishes services that are not covered under Medicare, the provider is not normally entitled to Medicare payment for those services. In order for payment to be made to a provider of care, Medicare law requires, at a minimum, that services be medically reasonable and necessary for the diagnosis or treatment of an illness or injury. It also excludes from payment care that is considered to be custodial in nature.

The program, however, has recognized that circumstances may exist where providers of services or beneficiaries could not have reasonably known that services would not be covered. Medicare has paid for a limited number of services which are not medically necessary or are determined to be custodial in nature, so long as it is determined that the provider or beneficiary did not know and could not reasonably have been expected to know that services would be uncovered. The provider is presumed not to know that coverage for certain services would be denied—it qualifies for a “favorable presumption”—when its denial rate is below a certain level. With this favorable presumption, its liability for denied claims below the threshold is waived and it is paid for these claims. The provider receives waiver of liability protection for denied claims below the threshold.

For home health agencies, waiver of liability protection is available for two separate categories of denials. One waiver applies to medical denials, i.e. to claims that are denied because the care was not medically necessary or was determined to be custodial in nature. Since 1987, another waiver has applied to services determined to be non-covered because the beneficiary was not “home-bound” or did not require “intermittent” skilled nursing care. These are referred to as technical denials.

For both categories, the principal criterion for meeting the favorable presumption test is a denial rate of 2.5 percent or less. Waiver of liability protection for both medical and technical denials expires November 1, 1990.

(3) *Extension of Waivers for Social Health Maintenance Organizations.*—The Deficit Reduction Act of 1984 (P.L. 98-369) required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations, which provide integrated health and long-term care services on a prepaid capitated basis. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) required the Secretary to extend the waivers through September 30, 1992.

(b) *Home Health Wage Index.*—Medicare pays home health agencies the reasonable cost of covered services subject to annual limits. The annual limits are set at 112 percent of the average labor and non-labor costs freestanding agencies incur in delivering services, with adjustments made in the labor-related portion of these average costs to reflect geographic variations in wage levels.

OBRA 87 required the Secretary to use a wage index for home health agency cost limits that is based upon audited wage data obtained from home health agencies, and to apply this index to cost

reporting periods beginning on or after July 1, 1988. The Medicare Catastrophic Coverage Act of 1988 delayed the application of the home health wage index to cost reporting periods beginning on or after July 1, 1989. On June 30, 1989, HCFA published the new wage index.

OBRA 89 included a provision that required the Secretary to continue using the hospital-based wage index for home health agency cost limits until cost reporting period beginning on or after July 1, 1991.

(c) *Clarification of Definitions Relating to Physician Ownership/Referral.*—Effective January 1, 1992, a physician is prohibited from referring a patient to a provider of clinical laboratory services with which the physician has a financial relationship.

(d) *Clarification of Payment to Hospital-Based Nursing Schools.*—The direct costs of approved medical education programs operated by a hospital are excluded from PPS and paid on a reasonable cost basis. HCFA has ruled that the costs of education programs operated at a hospital but controlled by another institution are not payable on a reasonable cost basis, but are included in PPS rates.

The Technical and Miscellaneous Revenue Act (TAMRA) of 1988 provided an exception to this rule for a hospital paid under a demonstration waiver that expired on September 30, 1985. Known as the "TAMRA exception," the law provided that if during such a hospital's FY 1985 cost reporting period, the hospital incurred substantial costs due to educational activities of a nursing college with which it shared common directors, the educational activities are considered to be allowable as reasonable costs under Medicare.

OBRA '89 provided that the educational costs incurred by a hospital-based nursing school are considered allowable costs if, prior to June 15, 1989, and thereafter, the hospital incurred substantial costs in training students and operating the school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or in the immediate proximity of the hospital. OBRA '89 also allowed a hospital paid under the TAMRA exception to be reimbursed for reasonable costs of training nursing students retroactively for hospital cost reporting periods beginning in FY 1986.

(e) *Case Management Demonstration Project.*—Case management is not a covered service under Medicare and there are no requirements under current law for Medicare beneficiaries to receive case management services. The Medicare Catastrophic Coverage Act, P.L. 100-360, authorized the establishment of four demonstration projects under which an appropriate entity agrees to provide case management services to Medicare beneficiaries with selected catastrophic illnesses. The demonstration was subsequently repealed in the repeal of the Medicare Catastrophic Coverage Act.

(f) *Payments for Graduate Medical Education.*—The direct costs of approved medical education programs (including the salaries of residents and teachers, and other overhead costs directly attributable to the medical education program for training residents, nurses, and allied health professionals) are excluded from PPS. The direct costs of training nurses and allied health professionals are paid on a reasonable costs basis. The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) replaced reasonable cost reimbursement for

graduate medical education (residency training programs for physicians) with formula payments based on each hospital's per resident costs. Medicare payments to each hospital are based on the product of: (1) the hospital's approved cost per full-time equivalent (FTE) resident; (2) the weighted average number of FTE residents; and (3) the percentage of inpatient days attributable to Medicare Part A beneficiaries.

Each hospital's per FTE resident amount is calculated using data from a base year, increased by 1 percent for hospital cost reporting periods beginning on or after July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. The number of FTE residents is calculated at 100 percent after July 1, 1986, only for residents in their initial residency period (defined as the minimum number of years of formal training necessary to satisfy specialty requirements for board eligibility plus 1 year, but not exceeding 5 years). For residents beyond the initial period of residency, the weighting factor is 0.50 FTE. Foreign medical school graduates are not counted as FTE residents unless they have passed certain designated examinations.

(g) *HCFA Service Fellows Program*.—No provision.

(h) *New Technology Intraocular Lenses*.—No provision.

(i) *Miscellaneous Technical Corrections*.—A home health aide training and competency evaluation program, or a competency evaluation program, may not be offered by or in a home health agency which, within the previous two years, has been determined to be out of compliance with the requirements specified in by Medicare. Deficient agencies are prohibited from training individuals who are responsible for providing much of patient care.

(j) *Psychology and Nurse-Midwife Services for Inpatients*.—OBRA '89 provided direct reimbursement for the services of clinical psychologists. In coverage instructions implementing this provision, the Health Care Financing Administration indicated that services rendered to inpatients of hospitals by clinical psychologists are directly reimbursable under Part B because they are "bundled" services for which hospitals are reimbursed.

House bill

(a) *Extension of Expiring Provisions*.—

(1) *Prohibition on Payment Cycle Changes*.—No provision.

(3) *Waiver of Liability for Home Health Agencies*.—No provision.

(4) *Extension of Waivers for Social Health Maintenance Organizations*.—No provision.

(b) *Home Health Wage Index*.—No provision.

(c) *Clarification of Definitions Relating to Physician Ownership/Referral*.—

(d) *Clarification of Payment to Hospital-Based Nursing Schools*.—No provision.

(e) *Case Management Demonstration Project*.—No provision.

(f) *Payments for Graduate Medical Education*.—Provides that, for residents in their initial residency period, a primary care resident is to be counted as 1.1 FTE; a resident specializing in internal medicine or pediatrics other than primary care is to be counted as 1.0 FTE; and all other residents is to be counted as 0.90 FTE. For residents beyond the initial three years of period of residency, in-

creases the weighting factor to 0.80 FTE. Defines primary care specialties as including family practice medicine, general internal medicine, or general pediatrics.

Limits the approved amount per FTE resident in each year to a set percent of the national median, adjusted for local costs, of the hospital specific approved FTE resident amounts. Provides that the approved FTE resident amount for a hospital is limited to 200 percent of the median of all approved FTE amounts for hospitals for cost reporting periods beginning in FY 1992, adjusted by the area wage index applicable to the hospital; lowers the cap to 175 percent in FY 1993, and to 150 percent in FY 1994.

Effective date: Enactment.

(g) *HCFA Service Fellows Program*.—No provision.

Effective date: No provision.

(h) *New Technology Intraocular Lenses*.—No provision.

(i) *Miscellaneous Technical Corrections*.—Modifies the conditions under which a home health agency is precluded from offering a home health aide training and competency program, or a competency evaluation program.

Effective date: Enactment.

(j) *Psychology and Nurse-Midwife Services for Inpatients*.—No provision.

Senate amendment

(a) *Extension of Expiring Provisions*.—

(1) *Prohibition on Payment Cycle Changes*.—Makes permanent the prohibition on the Secretary from issuing any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down or speeding up Medicare claims processing or delaying or increasing the rate at which claims are paid.

(2) *Waiver of Liability for Home Health Agencies*.—Extends the waiver of liability as applied to medical and technical denials through December 31, 1995.

(3) *Extension of Waivers for Social Health Maintenance Organizations*.—Extends the waivers for the social health maintenance organization (SHMOs) demonstration through December 31, 1995.

(b) *Home Health Wage Index*.—Requires the Secretary to use for home health agency cost limits the hospital wage index applicable during the fiscal year to the hospital located in the geographic area in which the home health agency is located. Specifies a transition period for phasing in the use of the 1988 hospital wage index. For home health agency cost reporting periods that begin between July 1, 1991 and June 30, 1992, the wage index would be based on a combined area wage index consisting of two-thirds of the 1982 hospital wage index now in use and one-third of the 1988 index. For cost reporting periods beginning between July 1, 1992 and June 30 1993, the combined area wage index would consist of one-third of the 1982 index and two-thirds of the 1988 index. For cost reporting periods beginning on or after July 1, 1993, the 1988 wage index or any later version that may be in effect would be used. Requires the Secretary, in updating the wage index for the limits, to provide that payments to home health agencies will be no greater or lesser

than payments would have been without regard to the update of the wage index.

Effective date: Applies to home health agency cost reporting periods beginning on or after July 1, 1993.

(c) *Clarification of Definitions Relating to Physician Ownership/Referral.*—Adds an exception to the prohibition on financial or compensation arrangements. The prohibition does not apply in the case of a referral for clinical laboratory services furnished by a hospital pursuant to a referral by a physician who has a financial relationship with a hospital that does not involve the provision of such services.

Effective date: Applies as if included in the enactment of OBRA 1989.

(d) *Clarification of Payment to Hospital-Based Nursing Schools.*—Establishes a payment policy for reimbursing hospitals for the clinical costs of hospital supported education programs. Prohibits the Secretary from recoupment of alleged overpayments made prior to October 1, 1990, for hospital supported education programs on the grounds that the costs were not allowable costs under Medicare.

Effective date: Enactment.

(e) *Case Management Demonstration Project.*—Requires the Secretary to resume three case management demonstration projects: (1) the project proposed to be conducted by Providence Hospital for case management of elderly at risk for acute hospitalization; (2) the project to be conducted by the Iowa Foundation for Medical Care to study patients with chronic congestive conditions to reduce repeated hospitalizations of such patients; and (3) the project to be conducted by Key Care Health Resources, Inc. to examine the effects of case management of 2,500 high cost Medicare beneficiaries. Requires that the projects be subject to the same terms and conditions established under the Medicare Catastrophic Coverage Act.

Effective date: Enactment.

(f) *Payments for Graduate Medical Education.*—Provides that, in the case of a hospital that had a graduate medical education program in FY 1984, and that made a commitment to expand its program that was not fully reflected in costs incurred during a cost reporting period beginning in that year, the hospital may request the use of an alternate base year for determining the approved amount per FTE resident. Requires the Secretary to assess the appropriateness of an alternate year based on per-resident amounts for comparable programs. Provides that, if the Secretary approves the request, payments based on the alternate base year will begin with the first cost reporting period for which the Secretary determines the expansion has been substantially implemented.

Effective date: Enactment.

(g) *HCFA Service Fellows Program.*—Section S. Authorizes the Administrator of the Health Care Financing Administration to establish a HCFA Fellows Service Program under which up to 10 individuals from the private sector or academia who have demonstrated exceptional competence, highly specialized skills or knowledge may conduct health care related research, studies and investigations within HCFA.

Qualified individuals may be appointed by the Administrator without regard to civil service personnel rules to serve for a period

not to exceed 2 years, except that extensions may be granted for up to two years in individual cases under exceptional circumstances. Individuals appointed as fellows are not to be included in determinations of full-time equivalent employees of the Department of Health and Human Services. Authorizes the Administrator to expend up to \$750,000 annually on the fellows program, including salary costs.

Effective date: Enactment.

(h) *New Technology Intraocular Lenses*.—Section 6145. Requires the Secretary to develop and implement a process by which interested parties may request review by the Secretary of the appropriate reimbursement under (incorrect section reference) with respect to a class of new technology intraocular lenses. Such lenses may not be considered as a class of new technology lenses unless they have been approved by the Food and Drug Administration.

Directs the Secretary to take into account whether use of the lens is likely to result in reduced risk of intraoperative or postoperative complication or trauma, accelerated postoperative recovery, reduced induced astigmatism, improved postoperative visual acuity, more stable postoperative vision or other comparable clinical advantages in determining whether to provide an adjustment of payment with respect to a particular lens.

Requires the Secretary to publish a notice in the Federal Register at least once a year of the requests that the Secretary has received for review of new technology IOLs. Requires the Secretary to provide a 60 day comment period on the notice and to publish a notice of his determination with respect to intraocular lenses listed in the notice within 120 days after the close of the comment period.

Effective date: Enactment.

(i) *Miscellaneous Technical Corrections*.—No provision.

Effective date: No provision.

(j) *Psychology and Nurse-Midwife Services for Inpatients*.—Section 6144. Provides for coverage and direct reimbursement for the services of clinical psychologists and certified nurse midwives rendered to individuals who are inpatients in hospitals.

Effective date: Section 6144. Effective for services furnished on or after January 1, 1991.

Conference agreement

7. Technical

(a) *Extension of Expiring Provisions*.—

(1) *Prohibition on Payment Cycle Changes*.—The conference agreement includes the Senate amendment with an amendment which makes permanent the prohibition on the Secretary from issuing any final regulation, instruction, or other policy change that is primarily intended to have the effect of slowing down or speeding up Medicare claims processing or delaying or increasing the rate at which claims are paid.

(2) *Waiver of Liability for Home Health Agencies*.—The conference agreement includes the Senate amendment.

(3) *Extension of Waivers for Social Health Maintenance Organizations (SHMOs)*.—The conference agreement includes the Senate amendment, with an amendment to require the Secretary to add

up to 4 additional SHMO demonstration projects not less than 1 year after the date of enactment of this act. The agreement requires that the new projects demonstrate the effectiveness and feasibility of innovative approaches to refining targeting and financing methodologies and benefit design, including the effectiveness and feasibility of (a) the benefits of expanded post-acute and community care case management through links between chronic care case management services and acute care providers; (b) refining targeting or reimbursement methodologies; (c) the establishment and operation of a rural services delivery system; or (d) the effectiveness of second-generation sites in reducing the costs of the commencement and management of health care service delivery. The agreement authorizes \$3.5 million for the costs of technical assistance and evaluation related to these projects.

The conference agreement also includes a provision that extends and clarifies the OBRA 1989 prohibition on cost-saving policies worth more than \$50 million issued in regulations prior to the end of the fiscal year. The conference agreement prohibits the Secretary from issuing any proposed or final regulation, instruction, or other policy which is estimated by the Secretary to reduce the Medicare current services baseline by more than \$50,000,000 with three exceptions: (a) the Secretary may issue proposed changes prior to May 15 preceding the fiscal year; (b) the Secretary may issue final regulation, instruction or other policy with respect to the fiscal year on or after October 15 of the fiscal year; (c) the Secretary may, at any time, issue such a proposed or final regulation, instruction, or other policy with respect to the final year if required to implement specific provisions required by the law. Applies for the period FY 1991-FY 1993, or if later, the last fiscal year for which there is a maximum deficit amount (i.e. Gramm-Rudman deficit target) specified under the Congressional Budget and Impoundment Control Act of 1974 (P.L. 93-344).

(b) Home Health Wage Index.—The conference agreement includes the Senate amendment with a modification to assure budget neutrality.

(c) Clarification of Definitions Relating to Physician Ownership/Referral.—The conference agreement includes the Senate amendment with a modification. The provision corrects technical drafting errors in the definition of referral by a referring physician. The term investor as having a specified financial relationship with an entity, including an ownership or investment interest, other than ownership in large, publicly traded corporations and certain other ownership or investment interests excepted under current law, or compensation arrangements other than those excepted under current law.

The modification excludes from reporting requirements certain entities which bill Medicare very infrequently, and claims from foreign providers. The Secretary is authorized to collect data from selected entities and selected States as opposed to all types of entities and all States. At a minimum, the Secretary is authorized to collect data in at least 10 States from parenteral and enteral suppliers, end stage renal disease facilities, ambulance services, hospitals, entities providing physical therapy services and entities providing diagnostic imaging services of all types (including but not limited

to magnetic resonance imaging, computerized tomography, mammography, sonography, and cardiac imaging).

The agreement also delays the requirement for issuance of regulations pertaining to physician ownership of clinical laboratories to October 1, 1991.

(d) Clarification of Payment to Hospital Based Nursing Schools.—The Conference agreement includes the House provision.

(e) Case Management Demonstration Project.—The conference agreement includes the Senate amendment, with an amendment to authorize \$2 million in each of the fiscal years 1991 and 1992 for administrative costs in carrying out the demonstrations.

(f) Payments for Graduate Medical Education.—See discussion of this issue in Part A and Part B.

(g) HCFA Service Fellows Program.—The Conference agreement does not include this provision.

(h) New Technology IOLs.—The Conference agreement does not include this provision.

(i) Miscellaneous Technical Corrections.—The Conference agreement includes the House provision.

(j) Psychology Services for Inpatients.—The Conference agreement includes the Senate amendment. The Conferees note that this section is not intended to change or override any other provision of Federal law or regulation or State law establishing the scope of practice for clinical psychologists or qualified psychologist services.

(1) Hospital and Physician Obligations with Respect to Emergency Medical Conditions.—The conference agreement changes the standard of liability for civil monetary penalties for physicians from “knowingly violates a requirement” to “negligently violates a requirement.” It changes the standard for excluding a physician from Medicare from a “knowing and willfull or negligent” violation of the requirements to a violation of the requirements which “is gross and flagrant or is repeated.” The provision applies to actions occurring on or after the first day of the six month after enactment.

The conference agreement also includes section 4103 of the House bill with an amendment to require the consultation of the Secretary with PROs with respect to allegations of violations of the provisions of requirements of section 1867 of the Social Security Act relating to the examination and treatment of emergency medical conditions. The provision requires the Secretary to require the appropriate PRO to review the medical condition of the individual and provide a report concerning its findings. Specifies that the PRO assess whether the individual had an emergency medical condition which had not been stabilized. The provision requires, except in the case in which a delay would jeopardize the health or safety of individuals, that the Secretary request such a review before terminating or suspending the provider from Medicare or imposing civil monetary penalties and to provide for at least 60 days for the review.

(2) Development of Prospective Payment System for Home Health Agencies.—The conference agreement requires the Secretary of HHS to develop for home health care a proposal to modify or replace the current reimbursement methodology with a prospective payment system.

In developing a prospective payment system, the Secretary is required to (1) take into consideration the need to provide for appropriate limits on increases in expenditures under the Medicare program; (2) provide for adjustments to prospectively determined rates to account for changes in a provider's case mix, severity of illness, volume of cases, and the development of new technologies and standards of medical practice; (3) take into consideration the need to increase the payment otherwise made under the new reimbursement system in the case of services provided to patients whose length of treatment or costs of treatment greatly exceed the length or cost of treatment provided for under the applicable prospectively determined payment rate; (4) take into consideration the need to increase payments under the system to providers that treat a disproportionate share of low-income patients and providers located in geographic areas with high wages and wage-related costs; and (5) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments under the system.

The Secretary is further required to submit the research findings upon which the home health prospective payment proposal will be based to the Senate Finance Committee and the House Ways and Means Committee by April 1, 1993. The Secretary would then submit the proposal to the Committee by September 1, 1993, and the Prospective Payment Assessment Commission would submit an analysis of and comments on the Secretary's proposal to the Committees by March 1, 1994.

3. Prohibition of User Fees for Survey and Certification.—The conference agreement provides that notwithstanding any other provision of law, the Secretary is prohibited from imposing, or requiring States to impose, on hospitals, nursing homes, hospices, dialysis facilities or other entities, a fee relating to offsetting the costs of surveys to certify compliance with the conditions of participation under Medicare Part A or Part B. The provision is effective upon enactment.

4. Anti Fraud and Abuse.—The conference agreement provides that the Secretary is authorized to delegate to the Office of the Inspector General enforcement of the anti-fraud and abuse provisions and to impose civil money penalties under specified law.

1. Part B Premium (Sections 12301 and 4201 of House bill; Section 6161 of Senate amendment)

Present law

Part B is a voluntary program financed by premiums paid by aged, disabled and chronic renal disease enrollees and by general revenues of the Federal Government. The premium rate is derived annually based partly upon the projected costs of the program for the coming year. The revised premium rate takes effect on January 1 of each year which coincides with the date for the annual Social Security cash benefit cost-of-living adjustment (COLA).

Ordinarily, the premium rate is the lower of (1) an amount sufficient to cover one-half of the costs of the program for the aged; or (2) the current premium amount increased by the percentage by

which cash benefits were increased under the COLA provisions of the Social Security program.

From 1984 through 1990, the premium was set at 25 percent of program costs for aged beneficiaries. The remaining 75 percent was covered by general revenues. In CY 1990, the basic Part B premium is \$28.60. In CY 1991, the calculation of the Part B premium is slated to revert to the earlier calculation method.

A special provision applies to low-income persons who have their premiums deducted from their social security checks. If there is a social security COLA that is less than the premium increase, the premium increase otherwise applicable is reduced to prevent a reduction in the individual's social security check.

House bill

Section 12301. Establishes the monthly Part B premium as follows:

1991.....	\$29.90
1992.....	\$31.70
1993.....	\$36.50
1994.....	\$41.20
1995.....	\$46.20

Section 4201. Retains, for 1991, the current law provision which provides for the calculation to return to the COLA calculation. An additional \$1 is added to this calculation.

Provides that for 1992-1995, the 25 percent rule is reinstated.

Effective date:

Section 12301. Applies to premiums beginning January 1, 1991.

Section 4201. Enactment.

Senate amendment

Retains, for 1991 and 1992 the current law provision which provides for the calculation to return to the COLA calculation.

Provides that for 1993-1995, the 25 percent rule is reinstated.

Effective date: Enactment.

Conference agreement

The conference agreement includes Section 12301 of the House bill with an amendment setting the Part B premium at \$29.90 for 1991, \$31.80 in 1992, \$36.60 in 1993, \$41.10 in 1994, and \$46.10 in 1995.

2. Part B Deductible (Sections 12302 and 4201 of House bill; Section 6162 of Senate amendment)

Present law

Part B of Medicare pays 80 percent of the reasonable charges (or of reasonable cost) for covered services in excess of an annual deductible of \$75. The part B deductible has been set at \$75 since 1982.

House bill

Section 12302. Sets the annual Part B deductible at \$100 for 1991-1995.

Section 4202. Increases the Part B deductible to \$100 beginning in 1991.

Effective date:

Section 12302. January 1, 1991.

Section 4202. Enactment.

Senate amendment

Sets the annual Part B deductible at \$150 for 1991-1995.

Effective date: Enactment

Conference agreement

The conference agreement includes Section 4202 of the House bill.

3. Coinsurance for Clinical Lab Services (Section 6163 of Senate amendment)

Present law

Medicare payment for clinical diagnostic laboratory tests, other than tests performed by a hospital or other provider for its inpatients, is made according to fee schedules established by the Secretary. The laboratory or physician providing these tests must accept assignment. Payments are made at 100 percent of the fee schedule, and the deductible and coinsurance are waived.

House bill

No provision.

Effective date: No provision.

Senate amendment

Imposes the 20 percent coinsurance for clinical diagnostic laboratory tests. The beneficiary must first meet the Part B deductible before payment is made by the program for covered clinical laboratory test expenses.

Provides that payment is made at 100 percent of the fee schedule amount for tests required in connection with a mandatory second or third opinion.

Effective date: Applies to clinical diagnostic laboratory tests performed on or after January 1, 1991.

Conference agreement

The conference agreement does not include the Senate amendment.

1. Reimbursement for Prescribed Drugs (Section 4401 of the House bill, section 6201 of the Senate amendment)

Present law

Coverage of prescription drugs is an optional Medicaid service that is provided by all States and the District of Columbia. Federal regulations require that States pay for drug ingredients subject to upper payment limits established by HHS, plus a reasonable professional dispensing fee established by the State. The Health Care Financing Administration of HHS has established upper payment

limits for some multiple source drugs. For some drugs, States have established upper payment limits. States may control utilization of prescribed drugs through various means including prior authorization requirements and denial of coverage for certain drugs or groups of drug products.

House bill

(a) *In General.*—Denies Federal matching funds for prescription drugs unless rebate agreements are in effect and States implement drug use review by January 1, 1993. Requires drug manufacturers to comply with rebate requirements in all States and the District of Columbia. Provides that, in the case of a manufacturer which has entered into and complies with an agreement, States will cover the manufacturer's covered outpatient drugs which are prescribed on or after April 1, 1991, for a medically accepted indication.

(b) *Requirement of Rebate Agreement.*—

(1) To ensure availability of payment for the covered drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement with the Secretary on behalf of all the States and the District of Columbia. Such agreement must be entered into by Feb. 1, 1991. If an agreement has not been entered into by that date, any agreement subsequently entered into is not effective until the first day of the first calendar quarter beginning more than 60 days after the agreement date.

(2) In the case of a rebate agreement in effect between a State and a manufacturer on October 1, 1990, such agreement may remain in effect and shall be considered to be in compliance if the State establishes to the satisfaction of the Secretary that the agreement can reasonably be expected to provide rebates at least as large as the rebates under this bill.

(3) Requirements for rebate agreements apply in the District of Columbia, and in the 50 States including any State that is providing medical assistance under a waiver granted under section 1115 of the Social Security Act. The requirements are not applicable in territories and commonwealths.

(4) *No provision.*

(c) *Terms of Rebate Agreement.*—(1) *Quarterly Rebates.* Under the rebate agreement, the manufacturer is required to provide each State Medicaid program with a rebate payment for the manufacturer's outpatient drugs in each calendar quarter. The rebate is to be paid within 30 days after receipt of the necessary information from the State, except that there is a special payment rule for the calendar quarter beginning July 1, 1991. With respect to that quarter, manufacturers' rebates are to be paid to each State by Sept. 30, 1991, based on the amount of the rebate payable for the previous quarter. The amount of the rebate payment for the quarter beginning Oct. 1, 1991, must be adjusted according to the extent that the rebate for the quarter beginning July 1, 1991 differed from the amount otherwise required to be made under the agreement. For purposes of Federal financial participation, the State's expenditures for medical assistance will be reduced by amounts received by a State as rebates.

(2) *State Provision of Information.*—Within 60 days of the end of each calendar quarter, each State Medicaid agency is required to

report to the Secretary information on the total number of units of each dosage form and strength of each covered outpatient drug of a manufacturer dispensed. Such information must be transmitted promptly to the manufacturer. A manufacturer may audit such data as are necessary to verify information provided by the State. Adjustments to rebates shall be made to the extent that information indicates utilization was more or less than the amount specified. Each State Medicaid agency is required to notify the Secretary within 30 days after receipt of each rebate.

(3) Manufacturer Provision of Price Information.—

(A) In General.—Each manufacturer with a rebate agreement must report, to the Secretary, within 30 days of the close of each calendar quarter (beginning on or after April 1, 1991), the average manufacturer price for covered outpatient drugs. The manufacturer must also report the manufacturer's best price for the quarter for single source drugs and innovator multiple source drugs. The information is to be made available on request to each State agency. The manufacturer is required to report to the Secretary, within 30 days of entering a rebate agreement on the best price in effect September 1, 1990, for each of the manufacturer's covered outpatient drugs. The information is to be made available on request to each State agency.

(B) Verification surveys of average manufacturer price.—When necessary to verify the average manufacturer prices reported, the Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs. If a wholesaler, manufacturer, or direct seller refuses a written request to provide information about charges or prices in connection with a survey, or knowingly provides false information, the Secretary may impose a civil monetary penalty up to \$10,000.

(C) Penalties.—Failure by a manufacturer to provide requested price information on a timely basis shall result in a 2 percent increase in the rebate next required to be paid for a calendar quarter. If the information is not provided within 90 days of the imposed deadline, a suspension of the rebate agreement of at least 30 days is imposed. A manufacturer who knowingly provides false information is subject to a civil money penalty of up to \$100,000 for each item of false information.

(D) Confidentiality of information.—Information disclosed by manufacturers or wholesalers is confidential and may not be disclosed by the Secretary or a State agency in a form which discloses the specific manufacturer, wholesaler, or product, except as deemed necessary by the Secretary and to permit review by the Comptroller General and the Inspector General.

(4) Length of Agreement.—A rebate agreement is effective for an initial period of 1 year and is automatically renewable for an additional 1 year period unless terminated by either party. The Secretary may terminate an agreement for violation of the requirements, effective 60 days or more after the date of notice of termination. If requested, the Secretary will provide a manufacturer a hearing which will not delay the effective date of termination. A manufacturer may terminate an agreement for any reason; the time from date of notice to effective date is specified by the Secretary. Any termination does not affect rebates due before the effective

tive date of termination. If an agreement has been terminated, a new agreement may not be entered into with the manufacturer (or successor manufacturer) until one year after the date of termination unless the Secretary finds good cause for earlier reinstatement.

(d) Amount of Rebate.—

(A) In General.—The rebate for single source drugs and innovator multiple source drugs (IMSDs) is the product of:

The amount by which the average manufacturer price during the quarter exceeds the manufacturer's best price for each dosage form and strength of a covered outpatient drug; and

The number of units dispensed to Medicaid beneficiaries in the State during the quarter.

For covered outpatient drugs other than single source drugs and IMSDs, the rebate is the product of:

10 percent of the average manufacturer price to wholesalers during the quarter (after deducting customary prompt payment discounts) for each dosage form and strength; and

The number of units dispensed to Medicaid beneficiaries in the State during the quarter.

(B) Minimum and Maximum Rebates for Single Source Drugs and Innovator Multiple Source Drugs (IMSDs).—Rebates for single source drugs and IMSDs are subject to minimum and maximum limits based on the product of the average manufacturer's price and the number of units dispensed. The minimum is 10 percent. For calendar quarters beginning before April 1, 1995 the maximum is 25 percent (for each quarter during the 8 calendar quarter period beginning April 1, 1991), or 50 percent (for each quarter during the 8 calendar quarter period beginning April 1, 1993).

(C) Best Price Defined.—Best price is the lowest price available for the drug during the calendar quarter (or, if lower, the lowest price in effect September 1, 1990, indexed to the CPI) from the manufacturer to any wholesaler, retailer, provider, non-profit entity, or governmental entity in the U.S. For new drugs, the "best price" is the lower of the lowest price on the market or the initial lowest price, indexed by the CPI.

The lowest price is inclusive of cash discounts, free goods, volume discounts, and rebates and is determined regardless of special packaging labelling or identifiers on the dosage form or product or package. The lowest price does not take into account nominal prices.

(D) Limitations on Coverage of Drugs.—States are required to cover a manufacturer's covered outpatient drugs prescribed for a medically accepted indication when the manufacturer which has entered into and complies with a rebate agreement. States are not required to cover any drug for which the manufacturer or its designee has imposed certain conditions of sale.

(e) Drug Use Review.—*(1) In General.*—In accordance with guidelines developed by the Agency for Health Care Policy and Research, each State must have a drug use review program in effect by January 1, 1993, for covered outpatient drugs (other than psychopharmacologic drugs dispensed to residents of nursing facilities) in order to assure that prescriptions are appropriate and medically

necessary. Each drug use review program is to comply with the requirements for prospective drug review, retrospective drug review, and education.

(2) *Description of Program.*—Prospective review involves review of drug therapy before a prescription is filled, typically at the point of sale or distribution. Pharmacists are required to use published compendia as the source of standards for review.

Retrospective review requires the periodic examination of claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care.

The State drug use review program must educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacies, and patients, or associated with specific drugs or groups of drugs. The program is also to identify potential and actual severe adverse reactions to drugs.

(f) *Miscellaneous.*—(1) States are not prevented from restricting the amount, duration, and scope of coverage of covered outpatient drugs consistent with the need to safeguard against unnecessary utilization.

(2) This bill does not affect or supersede provisions relating to maximum allowable cost limitation for covered outpatient drugs; rebates must be made without regard to whether payments by the State are subject to such limitations.

(3) States are not required to provide Medicaid coverage for covered outpatient drugs of a manufacturer which requires, as a condition for purchase, that the manufacturer be paid for associated services or tests provided only by the manufacturer or its designee.

(g) *Definitions.*—

Average Manufacturer Price Average manufacturer price is the average price paid to the manufacturer by retail pharmacies or by wholesalers for drugs distributed to the retail pharmacy class of trade.

Covered Outpatient Drug A covered outpatient drug is a prescribed drug which is approved under the Food, Drug and Cosmetic Act; which was commercially used or sold in the U.S. before enactment of the Federal Food, Drug and Cosmetic Act, and which has not been the subject of a final determination by the Secretary that it is a "new drug" under the Food, Drug and Cosmetic Act; for which the Secretary has not issued a notice for an opportunity for hearing because the drug is less than effective; and for which the Secretary has determined there is compelling justification for its medical need. Also included are identical, similar or related drugs.

The term includes a biological product which may only be dispensed by prescription, is licensed, and produced by a licensed establishment. Also included is insulin.

The term excludes any drug, biological product, or insulin provided with inpatient hospital services, hospice services, dental services (except where state plan authorizes direct reimbursement to dispensing dentist), physician office visits, outpatient hospital emergency room visits, and outpatient surgical procedures.

Non-prescription ("over-the-counter") drugs prescribed by a physician, or other authorized prescriber, may be regarded as covered outpatient drugs.

Manufacturer A manufacturer is the entity that both manufactures and distributes the drugs, or if no such entity exists, the entity that distributes the drug. The term does not include a wholesale distributor of drugs or a retail pharmacy.

Medically Accepted Indication A medically accepted indication means any use for a covered outpatient drug which is approved by the FDA or which is accepted by one of the following compendia: American Hospital Formulary Service—Drug Information, American Medical Association Drug Evaluations, and United States Pharmacopeia—Drug Information.

Multiple Source Drug; Innovator Multiple Source Drug; Noninnovator Multiple Source Drug; Single Source Drug.—(A) A multiple source drug is a covered outpatient drug for which there are 2 or more drug products sold or marketed in the State, which the Food and Drug Administration has rated as therapeutically equivalent and has determined are pharmaceutically equivalent and bioequivalent.

(B) Innovator multiple source drug means a multiple source drug that was originally marketed under an original new drug application approved by the Food and Drug Administration.

(C) Noninnovator multiple source drug means a multiple source drug that is not an innovator multiple source drug.

(D) Single source drug means a covered outpatient drug which is not multiple source drug.

Drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity.

Drug products are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

A drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, provided that the listed product is generally available to the public through retail pharmacies in that State.

(h) Funding.—Seventy-five percent Federal matching, over the 1991–1993 period, is available for the costs of the statewide adoption of a drug use review program meeting the requirements of the bill. Seventy-five percent Federal matching is available in FY 1991 for administrative activities related to meeting other requirements.

(i) Denial of Federal Financial Participation in Certain Cases.—No provision.

(j) Pharmacy Reimbursement.—No provision.

(k) Electronic Claims Management.—No provision.

(l) Annual Report.—No provision.

(m) Exemption of Organized Health Care Settings.—No provision.

(n) Demonstration Projects.—No provision.

(o) Studies.—No provision.

Senate amendment

(a) *In General.*—Similar, but does not include a date after which States must permit coverage of the drugs of a manufacturer which has entered into an agreement.

Prohibits the Secretary or a State from making any changes, prior to April 1, 1993, to the formula used to determine the reimbursement limits in effect as of Aug. 1, 1990, if those changes would result in reductions to the ingredient cost or dispensing fee for covered outpatient drugs.

Requires the Health Care Financing Administration to establish upper limits for all multiple source drugs for which the Food and Drug Administration has rated 3 or more therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such.

(b) *Requirement of Rebate Agreement.*—

(1) Similar provision, except permits the Secretary to authorize a State to enter directly in agreements with manufacturers, and requires that manufacturers enter into agreements by Jan. 1, 1991.

(2) For a rebate agreement in effect between a State and a manufacturer on the date of enactment of this bill, the agreement is considered to be in compliance for the initial agreement period if the State agrees to report to the Secretary any rebates paid under the agreement. The agreement is considered to be in compliance for renewal periods of the agreement if the State agrees to report any rebates to the Secretary, and the State establishes to the satisfaction of the Secretary that the agreement can reasonably be expected to provide rebates at least as large as the rebates otherwise required under this bill.

(3) No provision.

(4) Payment is authorized for single source drugs or innovator multiple source drugs not covered under rebate agreements if the State has made a determination that the availability of the drug is essential to the health of Medicaid beneficiaries; and the physician has received prior authorization for use of the drug, or the Secretary has approved the State's determination.

(c) *Terms of Rebate Agreement.*—(1) Quarterly rebates. Similar provision, but provides for periodicity other than quarterly, as specified by the Secretary. Does not include special payment rule.

(2) *State Provision of Information.*—States are required to report to each manufacturer within the same time period and copy each report to the Secretary. Places no limitations on audits by manufacturers. Otherwise similar provision.

(3) *Manufacturer Provision of Price Information.*—(A) *In General.*—Each manufacturer with a rebate agreement in effect is required to report to the Secretary the average manufacturer price within 30 days after each quarter beginning on or after January 1, 1991. The manufacturer's best price for single source drugs and innovator multiple source drugs is to be reported effective for quarters beginning on or after January 1, 1994. Within 30 days of entering into a rebate agreement, each manufacturer must report to the Secretary on the average manufacturer price for each of the manufacturer's drugs as of Oct. 1, 1990.

(B) *Verification surveys of average manufacturer price.*—Similar, but penalty applies whether request is written or not.

(C) *Penalties.*—Similar provision, except the rebate is increased by \$10,000 for each day information is not provided.

(D) *Confidentiality of information.*—Similar provision.

(4) *Length of Agreement.*—Similar provision.

(d) *Amount of Rebate.*—

(A) *In General.*—The basic rebate for single source drugs and innovator multiple source drugs (IMSDs) is the product of:

For quarters beginning after Dec. 31, 1990 and before Jan. 1, 1994, 15 percent of the average manufacturer price for each dosage form and strength (after deducting customary prompt payment discounts);

For quarters beginning after Dec. 31, 1993, the greater of

The difference between the average manufacturer price for a drug and 85 percent of the price, or

The difference between the average manufacturer price for a drug and the best price; and

The number of units of such form and dosage dispensed to Medicaid beneficiaries.

The Secretary is required to establish a method for ensuring that a manufacturer's prices, determined on an aggregate weighted average basis, using the average manufacturer price for each drug, do not increase by a percentage greater than the increase in the Consumer Price Index for all urban consumers (CPI-U) from Oct. 1, 1990.

For covered outpatient drugs other than single source drugs and IMSDs, the rebate is the product of:

12 percent of the average manufacturer price for each dosage form and strength (after deducting customary prompt payment discounts) and

The number of units dispensed.

In 1994 and beyond, rebates on single source drugs and IMSDs would be the greater of a 12 percent discount from the average manufacturer's price on Sept. 1, 1990, or the "best price". Rebates on drugs other than single source drugs and IMSDs would be discounts of 12 percent from the current average manufacturer's price.

The 12 percent minimum discount would be indexed annually by the CPI-U. A maximum discount of 20 percent would apply only in fiscal years 1991-1995.

(B) *Minimum and Maximum Rebates for Single Source Drugs and Innovator Multiple Source Drugs (IMSDs).*—No provision.

(C) *Best Price Defined.*—Best price is the lowest price available from the manufacturer excluding depot prices of any agency of the Federal Government. There is no provision for the best price of new drugs. Otherwise similar provision.

(D) *Limitations on Coverage of Drugs.*—Except in the first year following approval of a new drug, States are permitted to subject any covered outpatient drug to prior authorization. States may limit quantities of drugs, provided the limitations are necessary to discourage waste. States may exclude or restrict coverage of a drug if the prescribed use is not for a medically accepted indication, the drug is subject to an agreement between the manufacturer and the

State that is authorized by the Secretary, or the drug is in the list below.

The following drug products are subject to restriction:

Agents used for anorexia or weight gain that are not approved by the FDA;

Agents used to promote fertility;

Agents used for cosmetic purposes or hair growth;

Cough and cold relief agents;

Smoking cessation agents;

Prescription vitamins and minerals, except prenatal preparations;

Nonprescription drugs;

Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee;

Drugs determined by the Secretary to be less than effective; and

Barbiturates.

By regulation, the Secretary is required to periodically update the list.

Innovator multiple source drugs are to be treated as under otherwise applicable law and regulation.

States are prohibited from imposing prior authorization requirements unless its approval system is available at least 10 hours each weekday and provides for obtaining approval during other times, provides for response within 24 hours of a request, and provides for dispensing at least a 72 hour supply of a covered drug in an emergency situation.

(e) *Drug Use Review.*—(1) *In General.*—Similar provision, but requires the assessment of data on drug use against explicit predetermined standards consistent with certain compendia.

(2) *Description of Program.*—Similar provision specifies that prospective review shall include screening for certain drug therapy problems. Requires that State programs include standards established under State law for counseling of Medicaid recipients or caregivers by pharmacists. Counseling is to include at least a reasonable effort by the pharmacist to provide face-to-face counseling to discuss matters concerning the medication. The pharmacist is required to make a reasonable effort to obtain, record, and maintain certain information about the recipient. The pharmacist is not required to provide consultation when a recipient or caregiver refuses.

Similar provision for retrospective review.

Requires each State to establish a drug use review board (DUR board), either directly or through contract with a private organization, to provide for education outreach programs to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices. Specifies the membership of the board and specifies activities including intervention programs which include the following, as appropriate: information dissemination, reminders containing specific information and suggested changes in practices, discussions between health care professionals and prescribers and pharmacists targeted for educational interven-

tion, and intensified review of selected prescribers or dispensers. The board is required to evaluate interventions periodically.

Annually, each State is required to submit to the Secretary a report prepared by the DUR board. The report must include a description of the board's activities, a summary of the interventions, an assessment of their impact, and an estimate of the cost savings generated by the program.

(f) *Miscellaneous*.—Provisions similar to (1) and (3). No provision comparable to (2).

(g) *Definitions*.—Average Manufacturer Price Similar provision. Covered Outpatient Drug Similar provision.

Manufacturer.—A manufacturer is any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or in the packaging, repackaging, labeling, relabeling, or distribution of prescription drug products. The term does not include a wholesale distributor of drugs or a retail pharmacy.

Medically Accepted Indication.—Similar provision.

Multiple Source Drug; Innovator Multiple Source Drug; Noninnovator Multiple Source Drug; Single Source Drug.—Similar provision.

(h) *Funding*.—Similar provision.

(i) *Denial of Federal Financial Participation in Certain Cases*.—Denies Federal matching funds for an innovator multiple source drug dispensed on or after July 1, 1991, if a less expensive noninnovator multiple source drug could have been dispensed under State law.

(j) *Pharmacy Reimbursement*.—Within 60 days after the end of each fiscal year, beginning FY1991 and ending Sept. 30, 1993, each State Medicaid program is required to make a lump-sum payment, to pharmacies dispensing covered outpatient drugs under Medicaid during the fiscal year. The amount of payment is to bear the same ratio to 5 percent of the total rebates received by the State in the year, as the ratio of the number of prescriptions filled by a pharmacy bear to the total number of prescriptions filled by all pharmacies in the State in the fiscal year.

(k) *Electronic Claims Management*.—The Secretary must encourage each State to establish, as its principal means of processing claims for covered outpatient drugs under Medicaid, a point-of-sale electronic claims management system, for the purpose of performing eligibility verifications, capturing claims data, adjudicating claims, and assisting pharmacists to apply for and receive payment. During fiscal years 1991 and 1992, States may receive 90 percent Federal matching funds for the development of a system if the State acquires the most cost-effective services and equipment. The Secretary may permit States to substitute their requests for proposal for such systems in place of advance planning and implementation documents.

(l) *Annual Report*.—By May 1, of each year, the Secretary is required to submit a report to the appropriate committees of Congress. The report is to include information on ingredient costs paid

under Medicaid, the total value of rebates received and the number of manufacturers providing such rebates; comparison of these rebates with rebates offered to other purchasers; effect of inflation on the value of rebates; and trends in prices paid for drugs by Medicaid.

(m) *Exemption of Organized Health Care Settings.*—Health maintenance organizations are exempt from these requirements. States are required to exempt hospitals from these requirements provided the hospitals bill Medicaid no more than the hospital's acquisition costs for covered outpatient drugs. Amounts that health maintenance organizations and hospitals pay for covered outpatient drugs may be taken into account to determine the "best price".

(n) *Demonstration Projects.*—The Secretary is required to establish 10 statewide demonstration projects by January 1, 1992, to evaluate the efficiency and cost-effectiveness of prospective drug utilization review as a component of on-line, real-time electronic point-of-sales claims management. A report is due to Congress by January 1, 1994.

The Secretary is to conduct a demonstration project at no fewer than five sites to evaluate the impact on quality of care and cost-effectiveness of paying pharmacists, whether or not a drug is dispensed, for drug use review services. The Secretary is to report the results of the projects to Congress by January 1, 1995.

(o) *Studies.*—The Comptroller General is required to conduct a study, and submit a report to the Secretary and to Congress by May 1, 1991, of the drug purchasing and billing practices of hospitals, other institutional facilities, and managed care plans which provide covered outpatient drugs in the Medicaid program.

The Comptroller General is required to submit an annual report to the Secretary and to Congress by May 1, of each year, on changes in prices charged by manufacturers for prescription drugs sold to the Department of Veterans Affairs, other Federal programs, retail and hospital pharmacies, and other purchasing groups and managed care plans.

In consultation with the Comptroller General, the Secretary is required to study prior approval procedures used in State Medicaid programs, including appeals provisions and the effects of the procedures on access to medications. By December 31, 1991, the Secretary and Comptroller General must report the results of the study to Congress and make recommendations as to which procedures are appropriate for Medicaid.

By December 31, 1991, the Secretary is required to report to Congress on the results of a study on the adequacy of current reimbursement rates to pharmacists under each State Medicaid programs, and the extent to which the reimbursement rates affect beneficiary access to covered medications and to pharmacy services.

The Secretary is required to study the relationship between State Medicaid programs and governmental acquisition and reimbursement policies for vaccines, and the accessibility of vaccinations to children. The Secretary is required to report to Congress on the study within one year after the date of enactment of this Act.

The Comptroller General is required to conduct a study examining methods to encourage Medicare providers to negotiate dis-

counts with suppliers of prescription drugs. A report to Congress is due within one year after enactment of this section.

Conference agreement

1. Reimbursement for Prescribed Drugs.—

(a) *In General.*—The conference agreement includes the House bill with amendments to prohibit the Secretary and the States from reducing drug product reimbursement levels and dispensing fees for pharmacists from the levels in effect August 1, 1990, through March 30, 1995.

(b) *Requirement of Rebate Agreement.*—The conference agreement includes the House bill with the modification that rebate requirements would not apply to drugs of manufacturers with existing rebate contracts, through the minimum term of the contract, provided the amount of the rebate under the contract totals at least 10 percent of the manufacturer's sales to Medicaid in the State. States are permitted to impose prior authorization controls on all covered drugs, except new drugs within 6 months of FDA approval, and to exclude from coverage certain categories of drugs. States are permitted to cover non-rebated drugs with an FDA "A" rating if the State make a finding that the drug is essential to beneficiaries' health and the Secretary concurs, or if the State requires prior approval.

(c) *Terms of Rebate Agreement.*—The conference agreement includes the House bill.

(d) *Amount of Rebate.*—The conference agreement includes the House bill with the following amendments in calculation of the rebate amount for drugs prescribed on or after January 1, 1991. In the first year, the rebate amount is calculated on a drug-by-drug basis and is the greater of the difference between the average manufacturer price (AMP) and a specified percentage of the AMP, or the difference between the AMP and the best price, for sole source and innovator multiple source drugs. The rebate is subject to a maximum. In subsequent years, the rebate is to be calculated on an aggregate basis. The AMP is indexed according to the Consumers Price Index for all urban consumers. Rebates for multiple source (non-innovator) drugs are 10 percent of the AMP in years 1 through 3 and 11 percent in years 4 and 5 and thereafter with no adjustment for inflation. The rebate mechanism does not preclude imposition of current upper payment limits on multiple source drugs. The best price excludes depot prices of certain Federal agencies.

(e) *Drug Use Review.*—The conference agreement includes the House bill.

(f) *Miscellaneous.*—The conference agreement includes the House bill.

(g) *Definitions.*—The conference agreement includes the House bill.

(h) *Funding.*—The conference agreement includes the House bill with amendments that add 90 percent Federal matching funds in fiscal years 1991 and 1992 for electronic point of sale mechanisms.

(i) *Denial of Federal Financial Participation in Certain Cases.*—The Senate amendment is not included in the conference agreement.

(j) *Pharmacy Reimbursement*.—The Senate amendment is not included in the conference agreement.

(k) *Electronic Claims Management*.—The conference agreement includes the Senate amendment.

The conference agreement does not include provisions on annual report, exemption of organized health care settings, or demonstration projects.

2. *Requiring Medicaid Payment of Premiums and Cost-Sharing for Enrollment under Group Health Plans Where Cost-Effective. (Section 4402 of the House Bill, section 6211 of the Senate amendment)*

Present law

States may pay health insurance premiums on behalf of beneficiaries instead of providing Medicaid directly, so long as the beneficiaries are covered for the full scope of Medicaid services and retain freedom of choice of providers and the other rights of Medicaid beneficiaries. If a beneficiary is enrolled in a health insurance plan, regardless of whether premiums were paid by Medicaid, Medicaid is a secondary payer for any services covered under that plan.

House bill

Provides that a State (including a State operating a medical assistance program under a Federal demonstration waiver, but not including a commonwealth or territory) must: (a) establish guidelines for the identification of cases in which the enrollment of a beneficiary in a group health is cost-effective; (b) require such beneficiaries (or their parents) to enroll in the plan; and (c) pay any premiums, deductibles, coinsurance, and similar costs under that plan for services covered under Medicaid. Defines cost-effective as meaning that reductions in Medicaid payments are likely to be greater than the cost of paying premiums and cost-sharing.

Requires the State, in developing its guidelines for identifying cases, to take account of limited enrollment periods and cases in which a person not eligible for Medicaid would have to be enrolled to enroll the beneficiary. Provides that a child will not lose eligibility because of a parent's failure to enroll the child. Provides that State payments for premiums and cost-sharing are eligible for Federal matching payments. Permits a State to pay premiums on behalf of a person not eligible for Medicaid if this is necessary to enroll a beneficiary and if total premium payments would still be cost-effective, but prohibits Medicaid payment for cost-sharing for such a person.

Requires a provider treating beneficiaries enrolled under a plan to accept the greater of the plan's reimbursement rate or the Medicaid rate as payment in full, and prohibits a provider from charging the beneficiary or Medicaid an amount that would result in aggregate payment greater than the Medicaid rate. Provides that a beneficiary enrolled in a group health plan retains full eligibility for Medicaid benefits (subject to Medicaid's status as secondary payer), and permits the State to cover services included in the health plan that the State does not ordinarily cover under Medicaid. Provides that a State's failure to comply with requirements re-

lating to group health plans will not be considered in computing erroneous payments for the purpose of the Medicaid quality control system. Permits a State to continue payments on behalf of a beneficiary enrolled in a group health plan for a State-defined period of up to 6 months after enrollment even if the enrollee ceases to be eligible for Medicaid during that period, but only for services covered under the group plan.

Effective date: Applies to payments for quarters beginning on or after January 1, 1991, regardless of whether implementing regulations have been promulgated by that date. Delay permitted where State legislation required to comply.

Senate amendment

Requires States to pay premiums, deductibles, and coinsurance for private health insurance policies when it is cost-effective to do so. Requires the Secretary to promulgate regulations on criteria for determining cost-effectiveness, taking into account the duration of the time period to be considered, whether States should consider individual circumstances and actuarial categories (including diagnostically based categories), and the circumstances under which States should pay premiums for non-Medicaid eligible family members of Medicaid beneficiaries. Requires the State to provide directly any service covered under the State Medicaid and not covered under the private insurance plan. Provides that State payments for premiums and cost-sharing are eligible for Federal matching payments. Permits the State to pay premiums and cost-sharing for services included in the health plan that the State does not ordinarily cover under Medicaid.

Effective date: Applies to payments for quarters beginning on or after January 1, 1991. Delay permitted where State legislation required to comply.

Conference agreement

2. Requiring Medicaid Payment of Premiums and Cost-Sharing for Enrollment under Group Health Plans Where Cost-Effective.—The conference agreement includes the House bill with two modifications: (1) the Secretary is required to establish cost-effectiveness guidelines, and (2) States are required to pay all cost-sharing.

3. Computer Matching and Privacy Provisions. (Section 4403 of the House bill.)

Present law

A Federal or other agency participating in a program for computer matching of data about individuals may not deny, terminate, or reduce an individual's benefits under any Federal program on the basis of data obtained through that program (such as data about income and assets) unless the data have been independently verified and the individual has been notified and given an opportunity to contest the finding.

House bill

Provides that an adverse action may be taken on the basis of data that have not been independently verified when the data

relate to payments made under a Federal benefits program and the agency's Data Integrity Board (or, in the case of a non-Federal agency, the Board of the Federal agency issuing the payment) determines that the information is limited to information about the Federal payments and there is a high degree of confidence that it is accurate. Requires that this determination be made in accordance with guidelines to be published by the Director of the Office of Management and Budget (OMB) within 90 days after enactment. Provides that data supplied by Federal agencies administering the AFDC, Medicaid, and Food Stamp programs is exempt from the requirement that the Board certify to a "high degree of confidence" until the earlier of the date the agency's Board determines that there is not a high degree of confidence or 30 days after the publication of the OMB guidelines.

Effective date: Enactment.

Senate amendment

No provision.

Conference agreement

3. *Computer Matching and Privacy Provision.*—The conference agreement does not include the House bill.

4. *Protection of Low-Income Medicare Beneficiaries.* (Section 4411 of the House bill, section 6221 of the Senate amendment.)

Present law

(a) *Extending Medicaid Payment for Medicare Premiums for Certain Individuals.*—The Medicare Catastrophic Coverage Act of 1988 required States to pay Medicare premiums, deductibles, and coinsurance for "qualified Medicare beneficiaries" (QMBs), those whose family incomes are below 100 percent of the Federal poverty level and whose resources are no more than twice the amount allowed under SSI. The requirement is being phased in on a timetable that ends January 1, 1992, or January 1, 1993 in section 209(b) States that use more restrictive income limits for Medicaid than for SSI. For calendar year 1991, States are required to cover individuals up to 95 percent of the poverty level, or 90 percent in the section 209(b) States. States have the option of accelerating coverage of individuals up to 100 percent of the poverty level. OBRA 1986 also gave States the option of providing full Medicaid coverage (not just Medicare cost-sharing) to elderly and disabled persons with incomes up to 100 percent of the poverty level. The Federal contribution to payments for QMBs is made at the standard matching rate, which ranges from 50 to 83 percent depending on the State's per capita income.

(b) *Disregard of Cost-of-Living Adjustments.*—Whether an individual is determined to be a QMB depends on whether his or her income is less than a specified percentage of the Federal poverty level. Cost-of-living adjustments (COLAs) for cash benefits under Title II of the Social Security Act become effective on January 1 of a calendar year. The Federal poverty levels for a year are not updated until the middle of February of that year. As a result of this lag, an individual with income near (but below) the maximum

income level for QMBs for a year may lose eligibility in the following year until the new poverty levels are issued; new applicants with similar incomes may be denied coverage during the same interval.

House bill

(a) *Extending Medicaid Payment for Medicare Premiums for Certain Individuals.*—Requires all States (including States operating a medical assistance program under a demonstration waiver) to extend QMB coverage to otherwise qualified Medicare beneficiaries with incomes up to 125 percent of the Federal poverty level. Provides for 100 percent Federal matching for additional expenditures resulting from this requirement.

(b) *Disregard of Cost-of-Living Adjustments.*—Provides that, until the month following the month in which revised poverty guidelines are issued, income attributable to the COLA adjustment is to be excluded in determining eligibility for a QMB, or for an elderly or disabled individual receiving full Medicaid coverage under the OBRA 1986 option.

Effective date: (a) Applies to calendar quarters beginning on or after January 1, 1991, regardless of whether implementing regulations have been promulgated by that date. (b) Applies to determinations of income for months beginning with January 1, 1991.

Senate amendment

(a) *Extending Medicaid Payment for Medicare Premiums for Certain Individuals.*—Requires States to extend QMB coverage to Medicare beneficiaries with incomes up to 100 percent of the Federal poverty level by January 1, 1991. Requires section 209(b) States to extend coverage to individuals with incomes below 95 percent of the poverty level by January 1, 1991, and below 100 percent by January 1, 1992. Permits States to establish a higher income limit, up to 133 percent of the Federal poverty level.

(b) *Disregard of Cost-of-Living Adjustments.*—Similar provision, except applies to QMBs only.

Effective date: (a) Applies to calendar quarters beginning on or after January 1, 1991. Delay permitted where State legislation required. (b) Applies to determinations of income for months beginning with January 1, 1991.

Conference agreement

4. Protection of Low-Income Medicare Beneficiaries.

(a) *Extending Medicaid Payment for Medicare Premiums for Certain Individuals.*—The conference agreement includes the Senate amendments with an amendment to require all but 5 specified 209(b) States to accelerate current coverage for Medicare cost-sharing for beneficiaries with incomes up to 100 percent of the Federal poverty level by January 1, 1991. Requires States to pay premiums for qualified Medicare beneficiaries with incomes up to 110 percent of the Federal poverty level by January 1, 1993, and to 120 percent by January 1, 1995.

(b) *Disregard of Cost-of-Living Adjustments.*—The conference agreement follows the House bill with a modification which provides that income attributable to COLA adjustments is to be ex-

cluded in determining eligibility for QMBs during the first 3 months of a calendar year.

5. Improvements in Child Health (Sections 4421-4426 of the House bill, section 6231 of the Senate amendment.)

Present law

(a) Phased-in Mandatory Coverage of Children up to 100 Percent of Poverty Level.—States are required to cover children up to age 6 in families with incomes under 133 percent of the Federal poverty level. States are permitted to cover children born after September 30, 1983 up to 7 years old (or 8, at the State's option), in families with incomes below a State-established income level which may be as high as 100 percent of the Federal poverty level. In determining family income for these children, a State must use the same methodology used in its AFDC program, except that it may not deem as available to the applicant income of relatives other than a spouse or parent, and may not subtract from income costs for medical care.

(b) Optional Coverage of Children with Income Below 185 Percent of the Poverty Level.—States are permitted to cover pregnant women and infants up to one year old in families with incomes below a State-established level which may be as high as 185 percent of the Federal poverty level.

(c) Mandatory Continuation of Benefits Throughout Pregnancy or First Year of Life.—States have the option of continuing coverage for a pregnant woman through the end of the second full month beginning after the end of her pregnancy, even if the woman would otherwise become ineligible during that period. A child born to a woman eligible for and receiving Medicaid on the child's date of birth is deemed eligible for Medicaid and remains eligible so long as the child is a member of the woman's household and the woman remains eligible for Medicaid. During this period, the Medicaid eligibility identification number of the mother serves as the identification number for the child unless the State issues a separate identification number for the child before the end of the period.

(d) Mandatory use of Outreach Locations Other Than Welfare Offices.—States determine the sites at which applications for Medicaid will be accepted. For persons applying for Medicaid only, and not for cash assistance, a State may use the same application form used for the cash assistance programs or may develop a different form.

(e) Presumptive Eligibility.—

(1) Extension of Presumptive Eligibility Period.—States have the option of establishing "presumptive eligibility" for low-income pregnant women. Certain providers may make a preliminary determination that a pregnant woman seeking treatment is potentially eligible for Medicaid. The woman may then receive services related to the pregnancy for up to 45 days, or until the State completes an eligibility review, whichever is earlier. If a woman who has been determined by a provider to be presumptively eligible for Medicaid services fails to apply for Medicaid within 14 days after the determination is made, presumptive eligibility ceases.

(2) *Flexibility in Application.*—States design their own application forms for Medicaid benefits. In the case of pregnant women, some States may use different forms for the presumptive eligibility determination and the final eligibility determination, while others may use the same form for both. Current law has no provision on this subject.

(f) *Role in Paternity Determinations.*—Applicants of Medicaid are required, as a condition of eligibility, to cooperate in establishing the paternity of children born out of wedlock, and in obtaining child support unless there is good cause for non-cooperation.

(g) *Report and Transition on Errors in Eligibility Determinations.*—States are required to maintain a Medicaid quality control system, which identifies Medicaid payments made as a result of erroneous eligibility determinations. If a State's error rate (erroneous Medicaid payments as a percent of total Medicaid payments) exceeds 3 percent, it may be subject to a reduction in Federal matching funds.

(h) *Adjustment in Payment for Hospital Services Furnished to Low-Income Children.*—If a State pays for inpatient services on a prospective basis (under which payment rates are established in advance and may not reflect the hospital's actual costs for covered services), the State must provide additional payment to disproportionate share hospitals for patients under 1 year old who are "outliers", that is, who incur exceptionally high costs or have long hospital stays. States may establish reasonable durational limits on coverage of inpatient hospital services, but may not impose these limits on medically necessary services provided to children under 1 year old in hospitals serving a disproportionate number of low-income patients with special needs.

House bill

(a) *Phased-in Mandatory Coverage of Children up to 100 Percent of Poverty Level.*—Requires States to cover children born after September 30, 1983, who are over 6 years old but under 13 years old, with family incomes up to 100 percent of the Federal poverty level. Provides that in determining family income, States may use a methodology that is less restrictive than that used for AFDC.

(b) *Optional Coverage of Children with Income Below 185 Percent of the Poverty Level.*—No provision.

(c) *Mandatory Continuation of Benefits Throughout Pregnancy or First Year of Life.*—Requires all States to continue eligibility for pregnant women until the end of the second full month beginning after the end of the pregnancy, except in the case of a woman who has been provided ambulatory care during a presumptive eligibility period and then determined to be ineligible. Provides that an infant born to a woman who is eligible for Medicaid remains eligible until the first birthday, so long as the child remains in the mother's household and the mother remains eligible for Medicaid, or would be eligible if she were pregnant.

(d) *Mandatory Use of Outreach Locations Other Than Welfare Offices.*—Requires States to accept and begin processing applications by pregnant women and children under 18 at locations other than those used for the receipt and processing of applications for AFDC, and using different application forms. Other locations include dis-

proportionate share hospitals and federally qualified health centers.

(e) Presumptive Eligibility.—

*(1) Extension of Presumptive Eligibility Period.—*Extends the time limit for filing a Medicaid application to the last day of the month following the month in which the provider makes an initial determination of presumptive eligibility, and continues eligibility to that date in the case of a woman who fails to apply.

*(2) Flexibility in Application.—*Provides that the Medicaid application form to be filed by women who have been determined presumptively eligible may be the form used by the State for applications by women potentially eligible solely because of pregnancy.

*(f) Role in Paternity Determinations.—*Exempts women qualifying for Medicaid under the special eligibility standards for pregnant women from the requirement that they cooperate in establishing paternity and obtaining child support.

*(g) Report and Transition on Errors in Eligibility Determinations.—*Requires the Secretary of HHS to report to Congress by July 1, 1991, on error rates by States in determining eligibility of pregnant women and infants whose eligibility is based on income. Provides that the report may include data for medical assistance provided before July 1, 1989. Provides that the calculation of State error rates and financial penalties is to exclude Medicaid payments made on behalf of pregnant women and infants whose eligibility is based on income on or after July 1, 1989, and before the first calendar quarter beginning more than 12 months after the Secretary submits the required report.

*(h) Adjustment in Payment for Hospital Services Furnished to Low-Income Children.—*No provision.

Effective date.—(a) applies to payments for calendar quarters beginning on or after July 1, 1991, regardless of whether implementing regulations have been promulgated by that date. Delay is permitted where State legislation is required to comply. Texas is not required to comply with the requirements of (a) until September 1, 1991. (c) applies to infants from on or after January 1, 1991, regardless of whether implementing regulations have been promulgated by that date, and to determinations made on or after January 1, 1991, to terminate the eligibility of women based on change of income, regardless of whether implementing regulations have been promulgated by that date. (d) and (e)(1) apply to payments for calendar quarters beginning on or after July 1, 1991, regardless of whether implementing regulations have been promulgated by that date. (e)(2) is effective as if included in the enactment of section 9407(b) of OBRA 86. (f) is effective upon enactment.

Senate amendment

*(a) Phased-in Mandatory Coverage of Children up to 100 Percent of Poverty Level.—*Similar provision, but would require States to cover children up to age 19. Does not provide for changes in the methodology for determining family income.

*(b) Optional Coverage of Children with Income Below 185 Percent of the Poverty Level.—*Permits States to phase in coverage of children up to age 19 with family incomes under 185 percent of the Federal poverty level.

(c) *Mandatory Continuation of Benefits Throughout Pregnancy or First Year of Life.*—Similar provision also specifies that no new Medicaid application is required for a child if the State has issued a separate identification number before expiration of the deemed period.

(d) *Mandatory Use of Outreach Locations Other Than Welfare Offices.*—No provision.

(e) *Presumptive Eligibility.*—No provision.

(f) *Role in Paternity Determinations.*—No provision.

(g) *Report and Transition on Errors in Eligibility Determinations.*—No Provision.

(h) *Adjustment in Payment for Hospital Services Furnished to Low-Income Children.*—Requires States with prospective payment systems to provide for outlier payment adjustments for medically necessary inpatient services involving exceptionally high costs or exceptionally long lengths of stay when such services are provided (a) in disproportionate share hospitals to children over age 1 and under age 19, and (b) to infants under age 1 in any hospital. Prohibits States from imposing durational limits for medically necessary inpatient services provided in disproportionate share hospitals to children under age 19. Prohibits States from imposing durational limits or dollar limits on any inpatient hospital services to an individual who is under age 1 or, if an inpatient on his first birthday, until the individual is discharged. Prohibits the Secretary from waiving these requirements.

Effective Date: (a) and (b) apply to payments for calendar quarters beginning on or after July 1, 1991, regardless of whether implementing regulations have been promulgated by that date. Delay is permitted where State legislation is required to comply. (c) applies to eligibility determinations made on or after July 1, 1991. (h) applies to payments for calendar quarters beginning on or after July 1, 1991, regardless of whether implementing regulations have been promulgated by that date. Delay is permitted where State legislation is required to comply.

Conference agreement

5. Improvements in Child Health.—

(a) *Phase-in Mandatory Coverage of Children up to 100 Percent of Poverty Level.*—The conference agreement includes the Senate amendment.

(b) *Optional Coverage of Children with Income Below 185 Percent of the Poverty Level.*—The conference agreement does not include the Senate amendment.

(c) *Mandatory Continuation of Benefits Throughout Pregnancy or First Year of Life.*—The conference agreement includes the House bill.

(d) *Mandatory of Outreach Locations Other than Welfare Offices.*—The conference agreement includes the House bill.

(e) *Presumptive Eligibility.*—The conference agreement includes the House bill.

(f) *Paternity determination.*—The conference agreement includes the House bill.

(g) *Report and Transition on Errors in Eligibility Determinations.*—The conference agreement includes the House bill.

(h) *Adjustment in Payment for Hospital Services Furnished to Low-Income Children.*—The conference agreement includes the Senate amendment, with an amendment to limit the provisions to children under age 6.

6. *Nursing Home Reform Provisions (Section 4431 of House bill; section 6251 of Senate amendment)*

Present law

(a) *Nurse Aide Training.*—Effective October 1, 1990, nursing facilities (NFs) participating in Medicaid must use on their staffs as nurse aides only those persons who have completed approved training and competency evaluation programs. Specifically, the law prohibits NFs from using (on a full-time, temporary, per diem, or other basis) persons as nurse aides for more than 4 months, unless the aide (1) has completed a training and/or a competency evaluation program approved by the State; and (2) is competent to provide nursing or nursing-related services. The law also requires States to establish nurse aide registries of all persons who have satisfactorily completed training and competency evaluation programs and those persons who have been involved in resident neglect and abuse. Nursing homes are required to consult these registries before hiring a person as a nurse aide.

OBRA 87 required the Secretary to establish requirements for State approval of nurse aide training and competency evaluation programs by September 1, 1988, and to specify in these requirements areas to be covered in programs, content of curriculum, minimum hours of initial and ongoing training and retraining, qualification of instructors, and procedures for determining competency. The law prohibits the approval of training and competency evaluation programs offered by a NF, if the facility has been determined to be out of compliance with requirements for provision of services, residents' rights, and administration. In addition, an amendment included in OBRA 89 prohibits the approval of programs that impose charges for training and competency evaluation. In 1989, HCFA issued an interim guidance document, effective May 12, 1989, setting out approval criteria for the States. On March 23, 1990, HCFA published a proposed regulation on approval criteria for nurse aide training and competency evaluation programs.

OBRA 87 authorized enhanced Federal Medicaid matching payments for State activities required in connection with nurse aide training and competency evaluation programs. For the 8 calendar quarters beginning July 1, 1988, States have been authorized to receive for nurse aide training and competency evaluation activities their Federal matching rate, plus 25 percentage points, but not exceeding 90 percent. In subsequent years, the rate becomes 50 percent.

(b) *Preadmission Screening and Annual Resident Review.*—OBRA 87 requires States to establish preadmission screening and review programs to determine whether mentally ill or mentally retarded persons require the level of services provided by a nursing facility and whether they require active treatment. Effective January 1, 1989, NFs participating in Medicaid must not admit any new resident who is mentally ill or mentally retarded, unless the State has

determined, prior to admission, that the prospective resident requires the level of services provided by the facility, and whether he or she requires active treatment. OBRA also requires States to review, on an annual basis, all residents who are mentally ill or mentally retarded to determine whether their continued placement is appropriate and whether they require active treatment.

The first of these annual reviews was to have been completed April 1, 1990. These preadmission screening and annual resident review requirements are often referred to as PASARR requirements.

The law requires that certain residents be discharged from facilities if their placement is found to be inappropriate. OBRA authorized the Secretary of HHS and States to enter into agreements, prior to April 1, 1989, that specify alternative disposition plans (ADPs) for persons who must be discharged from facilities. ADPs provide additional time for the States to arrange for the disposition of persons who must be discharged.

OBRA required the Secretary to issue by October 1, 1988, minimum criteria for States to use in making determinations as to whether a mentally ill or mentally retarded individual requires the level of services provided by a nursing facility. In May, 1989, HCFA issued interim guidelines (effective May 26) to the States for use in making determinations. On March 23, 1990, HCFA published proposed regulations on requirements for PASARR. HCFA's interpretation of the law has been that PASARR applies to all individuals with mental illness or mental retardation who apply to reside in a Medicaid-certified NF, regardless of the source of payment for the NF services.

(c) Enforcement Process.—OBRA 87 revises and expands the sanctions that States and the Secretary may impose against nursing facilities found to be out of compliance with the requirements for participation. OBRA required States to amend their Medicaid plans by October 1, 1989, to include certain sanctions that they could impose against noncompliant nursing facilities. OBRA also required the Secretary to provide guidance to the States on these sanctions by October 1, 1988, but specified that the failure of the Secretary to provide this guidance did not relieve a State of its responsibility for establishing the sanctions by the statutory deadline. The Secretary has not yet issued regulations or guidelines providing this guidance.

(d) Supervision by Nurse Practitioners and Clinical Nurse Specialists.—OBRA 87 requires that the health care of every resident be provided under the supervision of a physician. Current Medicaid law allows States to pay for care provided by licensed practitioners, including nurse practitioners and clinical nurse specialists, within the scope of their practice as defined by State law.

(e) Other Amendments.—

(1) Assurance of Appropriate Payment Amounts.—OBRA 87 requires States to take into account in their payments to nursing facilities the costs of complying with new requirements relating to the provision of services, residents' rights, and administration. OBRA also requires that each State submit to the Secretary a State plan amendment to provide for an appropriate adjustment in payment amounts for nursing facility services.

(2) *Disclosure of Information of Quality Assessment and Assurance Committees.*—OBRA 87 requires that nursing facilities maintain a quality assessment and assurance committee which (1) meets at least quarterly to identify quality assessment and assurance issues, and (2) develops and implements appropriate plans of action to correct identified quality deficiencies.

(3) *Period for Resident Assessment.*—OBRA 87 requires that nursing facilities conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be performed promptly upon, but no later than 4 days after, admission to the facility.

(4) *Clarification of Responsibility for Services for Mentally Ill and Mentally Retarded Residents.*—OBRA 87 requires nursing facilities to provide nursing and related services and specialized rehabilitative services, medically-related social services, pharmaceutical services, dietary services, an ongoing program of activities, and certain dental services.

(5) *Clarification of Extent of State Waiver Authority.*—Nursing facilities participating in Medicaid are required to provide 24-hour licensed nursing care sufficient to meet the nursing needs of residents and to use a registered professional nurse at least 8 consecutive hours a day 7 days a week. OBRA 87 authorized States to waive the licensed nurse or registered nurse requirements if (1) the facility demonstrated that it has been unable to recruit appropriate personnel, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities); (2) the State determines that a waiver will not endanger the health or safety of residents; and, (3) a registered nurse or physician is obligated to respond immediately to telephone calls from the facility. These waivers are subject to annual renewal and to review by the Secretary of HHS.

(6) *Clarification of Definition of Nurse Aide.*—Nurse aides are defined as persons providing nursing or nursing-related services to residents in a nursing facility, but does not include certain licensed health professionals or volunteers providing services without monetary compensation.

(7) *Clarification of Requirements for Social Services.*—Nursing facilities with more than 120 beds are required to have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

(8) *Charges Applicable in Cases of Certain Medicaid-Eligible Individuals.*—There are circumstances in which, under current law, a State may not actually be making payments to a nursing home on behalf of a resident who is eligible for Medicaid. For example, a nursing home resident may be receiving Veterans' Administration aid and attendance payments. These payments are not taken into account in determining initial eligibility for Medicaid, but are considered, post-eligibility, in determining the amount of an individual's monthly income that is available to be applied to the cost of care. In certain situations, the income of the individual may exceed Medicaid payment levels for nursing home care. Nursing facilities have charged these residents at higher "private pay" rates, even though these residents are Medicaid eligible.

(9) *Residents' Rights to Refuse Transfers.*—Medicare nursing home residents must occupy a Medicare-certified bed in order for a facility to receive Medicare payment. In order to occupy such a bed, a resident may have to be moved.

(10) *Residents' Rights Regarding Advance Directives.*—OBRA 87 established in Medicaid statute a wide range of residents' rights that nursing facilities must protect and promote.

(11) *Resident Access to Clinical Records.*—OBRA 87 requires nursing facilities to assure the confidentiality of a resident's personal and clinical records.

(12) *Inclusion of State Notice of Rights in Facility Notice of Rights.*—Among the residents' rights established under OBRA 87 is the requirement that nursing facilities make available to each resident, upon reasonable request, a written statement of rights of the resident in the facility.

(13) *Removal of Duplicative Qualifications of Nursing Home Administrators.*—OBRA 87 requires the administrator of a nursing facility to meet standards established by the Secretary.

(14) *Clarification of Nurse Aide Registry Requirements.*—States are required to establish nurse aide registries of all persons who have satisfactorily completed training and competency evaluation programs and those persons who have been involved in resident neglect and abuse.

(15) *Clarification on Findings of Neglect.*—States (through their agencies responsible for surveys and certification of nursing facilities) are required to review, investigate, and make findings regarding allegations of resident neglect and abuse and misappropriation of resident property by a nurse aide or another individual used by the facility to provide services.

(16) *Timing of Public Disclosure of Survey Results.*—OBRA 87 requires States and the Secretary to make available to the public information on all surveys and certifications of nursing facilities, including statements of deficiencies and plans of correction.²

(17) *Denial of Payment of Legal Fees for Frivolous Litigation.*—Medicaid law specifies conditions under which Federal matching payments will be made available to the States.

(18) *Standards for Certain Professional Services.*—OBRA 87 requires NFs to provide, directly or under arrangements, various kinds of services, including medically-related social services, dietary services, and an on-going program of activities. Final regulations published by HCFA on February 2, 1989, and effective October 1, 1990, specify qualifications for the persons providing these services. These are often different from regulations in effect prior to October 1.

(19) *Ombudsman Program Coordination with State Medicaid and Survey and Certification Agencies.*—States are required to notify State long-term care ombudsman (established under the Older Americans Act) of survey findings of noncompliance with any of the requirements for participation.

House bill

(a) *Nurse Aide Training.*—Includes a number of amendments to the nurse aide training and competency evaluation requirements:

(1) *No Compliance Actions Before Effective Date of Guidelines.*—Prohibits the Secretary from taking (and continuing) any actions against a State for its failure to meet the law's requirements for nurse aide training and competency evaluation programs before the effective date of HCFA guidelines for such programs, if the State demonstrates it has made a good faith effort to meet the requirements before the effective date.

(2) *Clarification of Grace Period for Nurse Training of Individuals.*—Specifies that training and competency evaluation requirements apply to all persons who have worked (on a full-time, temporary, or per diem basis) as nurse aides for 90 days or more in any nursing facility.

(3) *Clarification of Nurse Aides Not Subject to Charges.*—Clarifies that the prohibition on charging nurse aides for training and competency evaluation would apply to aides who are employed by (or who have entered into an employment agreement with) a facility.

(4) *Modification of Nursing Facility Deficiency Standards.*—Prohibits approval of training and competency evaluation programs offered by or in a NF which, within the previous 2 years, has had a waiver for the licensed nurse or registered nurse requirements or has been subject to an extended (or partial extended) survey.

(5) *Clarification of State Responsibility to Determine Competency.*—Prohibits States from using subcontracts or other devices to determine that an aide is competent to provide nursing and nursing-related services.

(6) *Extension of Enhanced Match Rate Until October 1, 1990.*—No provision.

(7) *Nurse Aide Registry.*—Requires that nurse aides deemed to have met nurse aide training and competency evaluation requirements under OBRA 87 or OBRA 89 be added to a State's nurse aide registry. Further prohibits States from imposing any charges on aides for establishing and maintaining the registries. (Also described below in Other Amendments, item (d)(14).)

(8) *Retraining of Nurse Aides Not Employed.*—No provision.

(b) *Preadmission Screening and Annual Resident Review.*—Includes a number of amendments to PASARR requirements:

(1) *No Compliance Actions Before Effective Date of Guidelines.*—Prohibits the Secretary from taking (and continuing) any actions against a State for its failure to meet the law's requirements for preadmission screening before the effective date of HCFA guidelines, if the State demonstrates that it had made a good faith effort to meet the requirements.

(2) *Clarification with respect to Admissions and Readmission from a Hospital.*—Provides that preadmission screening requirements do not apply to nursing facility residents who are being readmitted to the nursing facility after a hospital stay. Also provides that preadmission screening requirements do not apply to persons (1) who are admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; (2) who require nursing facility services for the condition for which the individual received care in the hospital; and (3) whose attending physician has certified, before admission to the facility, that the person is likely to require less than 30 days of nursing facility services.

(3) *Delay in Application to Private Pay Residents.*—Provides that preadmission screening and annual resident review requirements do not apply to mentally ill or mentally retarded persons who are not eligible for Medicaid until such time as they become entitled to benefits (with preadmission screening required to be done at the end of the day following the date the person becomes eligible). Specifies that this amendment shall not prohibit a State from imposing preadmission screening and annual resident review requirements on persons who are not Medicaid eligible at the time of admission to a nursing facility. Prohibits the Secretary from imposing any sanction on States which have failed to apply the preadmission screening requirements to persons who are not Medicaid eligible at the time of their admission.

(4) *Denial of Payments for Certain Residents Not Requiring Nursing Facility Services.*—Prohibits Federal matching payments for nursing facility services for persons who do not require the level of services provided by the nursing facility (other than for persons who have resided in the facility for at least 30 months and who are determined not to need such care).

(5) *No Delegation of Authority to Conduct Screening and Reviews.*—Prohibits State mental health authorities and State mental retardation or developmental disability authorities from delegating (by subcontract or otherwise) their PASARR responsibilities to nursing facilities (or entities that have a direct or indirect affiliation or relationship with these facilities).

(6) *Annual Reports.*—Requires States to report to the Secretary annually on the number and disposition of residents who are discharged from nursing facilities (1) because they do not require nursing facility care, have resided in the facility for less than 30 months and require active treatment, and (2) because they do not require nursing facility care and do not require active treatment. Also requires the Secretary's annual report on nursing facility compliance with new requirements and enforcement actions to include a summary of information reported by States on the disposition of residents discharged from nursing homes.

(7) *Revision of Alternative Disposition Plans.*—Authorizes States to revise their agreements for alternative disposition plans before October 1, 1991, subject to the approval of the Secretary, but only if under the revised agreement all residents who do not require nursing facility care are discharged from the facility by not later than April 1, 1994.

(8) *Definition of Mentally Ill.*—Modifies the definition of mental illness from "a primary or secondary diagnosis of mental disorder (as defined in DSM-III)" to a "serious mental illness as defined by the Secretary."

(9) *Substitution of "Specialized Services" for "Active Treatment."*—Substitutes the term "specialized services" for the term "active treatment."

(c) *Enforcement Process.*—Prohibits the Secretary from taking (and continuing) any action against a State for its failure to meet the law's requirements for establishing sanctions before the effective date of guidelines, if the State demonstrates that it has made a good faith effort to meet the requirements.

(d) *Supervision by Nurse Practitioners and Clinical Nurse Specialists.*—Permits nursing facilities to use nurse practitioners or clinical nurse specialists who are not employees of the facility but who are working in collaboration with a physician to supervise the care of residents.

(e) *Other Amendments.*—

(1) *Assurance of Appropriate Payment Amounts.*—Requires that States also take into account in their payments to nursing facilities the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for Medicaid. Also requires that State plan amendments include a detailed description of the specific methodology to be used in determining the appropriate adjustment in payment amounts for nursing facility services.

(2) *Disclosure of Information of Quality Assessment and Assurance Committees.*—Provides that a State or the Secretary may not require disclosure of the records of the quality assessment and assurance committee, except for determining the facility's compliance with the requirement for maintaining the committee.

(3) *Period for Resident Assessment.*—Extends the time limit for a resident's assessment from 4 days to 14 days after admission.

(4) *Clarification of Responsibility for Services for Mentally Ill and Mentally Retarded Residents.*—Requires that facilities also provide treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

(5) *Clarification of Extent of State Waiver Authority.*—Clarifies that States may waive the licensed nurse or registered nurse requirements under the conditions specified in law, only to the extent that a facility is unable to meet them.

(6) *Clarification of Definition of Nurse Aide.*—Clarifies that nurse aides do not include registered dietitians.

(7) *Clarification of Requirements for Social Services.*—Provides that nursing facilities with more than 120 beds would be required to have one individual employed full-time to provide or assure the provision of social services who (1) is a social worker with at least a bachelor's degree in social work or similar professional qualifications; or (2) is provided with on-going consultation and assistance by a social worker (with the above qualifications) employed by the facility.

(8) *Charges Applicable in Cases of Certain Medicaid-Eligible Individuals.*—Prohibits nursing facilities from charging residents who are Medicaid eligible, but for whom Medicaid payments are not being made because their income exceeds State payments for this care, more than the Medicaid rate for their nursing facility care.

(9) *Residents' Rights to Refuse Transfers.*—Adds to residents' rights established under OBRA 87 a new right for residents to refuse a transfer to another room within a facility, if a purpose of the transfer is to relocate the resident from a non-Medicare certified portion of the facility to a Medicare-certified portion of the facility. Provides that a resident's refusal to be transferred will not affect the resident's eligibility for Medicaid or the State's entitlement to Federal matching payments for the resident's care.

(10) *Residents' Rights Regarding Advance Directives.*—Adds to residents' rights the right to compliance by the facility with the provisions of an advance directive. Defines "advance directive" as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law and relating to the provision of care when the individual is incapacitated.

(11) *Resident Access to Clinical Records.*—Adds to this requirement the right of the resident to have access to current clinical records promptly upon request.

(12) *Inclusion of State Notice of Rights in Facility Notice of Rights.*—Requires facilities to include in the written statement of rights that they are currently required to provide residents, a copy of the State notice of the rights and obligations of residents (and spouses of residents) under Medicaid.

(13) *Removal of Duplicative Qualifications of Nursing Home Administrators.*—Repeals other requirements in Medicaid law pertaining to State programs for the licensing of nursing home administrators.

(14) *Clarification of Nurse Aide Registry Requirements.*—Requires that nurse aides deemed to have met nurse aide training and competency evaluation requirements under OBRA 87 or OBRA 89 be added to a State's nurse aide registry. Also prohibits States from imposing any charges on aides for establishing and maintaining the registries.

(15) *Clarification on Findings of Neglect.*—Provides that a State can not make a finding of neglect by an individual, if the individual demonstrates that neglect was caused by factors beyond the control of the individual.

(16) *Timing of Public Disclosure of Survey Results.*—Requires that survey and certification information be made available to the public within 14 calendar days after this information is made available to the facilities.

(17) *Denial of Payment of Legal Fees for Frivolous Litigation.*—Specifies that Federal matching payments will not be made for reimbursing (or otherwise compensating) a nursing facility for legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for such action.

(18) *Standards for Certain Professional Services.*—No provision.

(19) *Ombudsman Program Coordination with State Medicaid and Survey and Certification Agencies.*—No provision.

Effective date: (a) effective as if included in OBRA 87; (b) effective as if included in OBRA 87, except that (c)(3), (5), (7), and (9) effective enactment, without regard to whether or not regulations to implement the amendments have been promulgated; (c) effective enactment; (d) effective with respect to services furnished on or after October 1, 1990, without regard to whether or not final regulations to implement the amendments have been promulgated; and (e) effective as if included in OBRA 87, except that (e)(8) effective enactment, without regard to whether or not regulations to implement the amendments have been promulgated, and (d)(13) effective October 1, 1990.

Senate amendment

(a) *Nurse Aide Training*.—Includes a number of amendments to the nurse aide training and competency evaluation requirements:

(1) *No Compliance Actions Before Effective Date of Guidelines*.—Identical provision, except prohibits actions against a State before the effective date of final regulations.

(2) *Clarification of Grace Period for Nurse Training of Individuals*.—Provides that NFs may not use individuals as nurse aides on a temporary, per diem, or any other basis on or after January 1, 1991, unless the individual meets the training and competency evaluation requirements that apply to full-time aides.

(3) *Clarification of Nurse Aides Not Subject to Charges*.—Permits accredited nonfacility-based nurse aide training and competency evaluation programs to impose charges on individuals who are not presently employed by a nursing facility or who have not yet had an offer for future employment at a facility. Further requires, for individuals employed or under contract for employment as a nurse aide within 12 months after successful completion of a nonfacility-based, State-approved nurse aide training and competency evaluation program, that the State ensure that the costs they incurred for these programs are reimbursed to them.

(4) *Modification of Nursing Facility Deficiency Standards*.—Provides that a NF would be ineligible to offer a training and competency evaluation program (1) if at any time on or after October 1, 1988, the facility has been terminated from participation in Medicaid or Medicare, until after the end of a period of at least 2 years during which no survey or investigation finds any deficiencies warranting termination and at least one standard survey has been conducted; or (2) the facility received a notice of termination at any time during the one year period ending September 30, 1990, until after the completion of a subsequent standard survey which finds no deficiencies warranting the notice; or (3) is found in a standard survey or investigation to have deficiencies resulting in a civil monetary penalty in excess of \$5,000, denial of payment, or appointment of temporary management, until after the completion of a subsequent standard survey which finds no deficiencies warranting these sanctions.

(5) *Clarification of State Responsibility to Determine Competency*.—Identical provision.

(6) *Extension of Enhanced Match Rate Until October 1, 1990*.—Extends enhanced Federal matching for nurse aide training and competency evaluation through September 30, 1990.

(7) *Nurse Aide Registry*.—Requires that aides deemed under OBRA 89 to have met the law's training and competency evaluation requirements and those aides for whom the State may waive the competency evaluation requirements under OBRA 89 be added to a State's nurse aide registry. Further requires NFs, that have reason to believe that a nurse aide they are considering employing is from a State other than the State in which the facility is located, to consult the nurse aide registry of the State where the facility believes the aide resided. (8) *Retraining of Nurse Aides Not Employed*.—Requires those nurse aides who have not provided services for 24 consecutive months to complete either a nurse aide training

and competency evaluation program or a new competency evaluation program.

(b) *Preadmission Screening and Annual Resident Review*.—Includes a number of amendments to the PASARR requirements:

(1) *No Compliance Actions Before Effective Date of Guidelines*.—Identical provision, except prohibits actions against the States before the effective date of final regulations.

(2) *Clarification with Respect to Admissions and Readmission from a Hospital*.—Identical provision.

(3) *Delay in Application to Private Pay Residents*.—No provision.

(4) *Denial of Payments for Certain Residents Not Requiring Nursing Facility Services*.—No provision.

(5) *No Delegation of Authority to Conduct Screening and Reviews*.—Identical provision.

(6) *Annual Reports*.—Identical provision.

(7) *Revision of Alternative Disposition Plans*.—Identical provision, except allows revision of alternative disposition plans before April 1, 1991.

(8) *Definition of Mentally Ill*.—Modifies the definition of mental illness to a "serious mental illness (as defined by the Secretary in consultation with the National Institute of Mental Health)." Retains the existing exclusion from PASARR for persons with a primary diagnosis of dementia (including Alzheimer's disease or related disorder) and also excludes persons with a nonprimary diagnosis of dementia and a primary diagnosis that is not a serious mental illness.

(9) *Substitution of "Specialized Services" for "Active Treatment"*.—Identical provision.

(c) *Enforcement Process*.—Delays until April 1, 1991, the requirement that States establish in their Medicaid plans certain sanctions to be imposed against noncompliant nursing facilities.

(d) *Supervision by Nurse Practitioners and Clinical Nurse Specialists*.—No provision.

(e) *Other Amendments*.—

(1) *Assurance of Appropriate Payment Amounts*.—No provision.

(2) *Disclosure of Information of Quality Assessment and Assurance Committees*.—No provision.

(3) *Period for Resident Assessment*.—Identical provision.

(4) *Clarification of Responsibility for Services for Mentally Ill and Mentally Retarded Residents*.—No provision.

(5) *Clarification of Extent of State Waiver Authority*.—Requires the State agency granting a waiver of nurse staffing requirements to provide notice of the waiver to the appropriate State and sub-state long-term care ombudsman, to the protection and advocacy system and other appropriate State and private agencies. Further requires a nursing facility that is granted a waiver make reasonable efforts to notify present and prospective residents of the facility (or a guardian or legal representative of residents) of the waiver.

Further requires the Secretary to conduct a study and report to Congress by January 1, 1992, on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for NFs. Requires that if the Secretary determines that the establishment of minimum ratios is advisable, the report must specify appropriate ratios or standards.

(6) *Clarification of Definition of Nurse Aide.*—No provision.

(7) *Clarification of Requirements for Social Services.*—No provision.

(8) *Charges Applicable in Cases of Certain Medicaid-Eligible Individuals.*—No provision.

(9) *Residents' Rights to Refuse Transfers.*—No provision.

(10) *Residents' Rights Regarding Advance Directives.*—No provision.

(11) *Resident Access to Clinical Records.*—Similar provision, except provides access as well to the resident's legal representative and specifies promptly upon reasonable request (as defined by the Secretary).

(12) *Inclusion of State Notice of Rights in Facility Notice of Rights.*—No provision.

(13) *Removal of Duplicative Qualifications of Nursing Home Administrators.*—No provision.

(14) *Clarification of Nurse Aide Registry Requirements.*—Requires that aides deemed under OBRA 89 to have met the law's training and competency evaluation requirements and those aides for whom the State may waive the competency evaluation requirements under OBRA 89 be added to a State's nurse aide registry. Further requires NFs, that have reason to believe that a nurse aide they are considering employing is from a State other than the State in which the facility is located, to consult the nurse aide registry of the State where the facility believes the aide resided. (Also described above under Nurse Aide Training, item (a)(7).)

(15) *Clarification on Findings of Neglect.*—No provision.

(16) *Timing of Public Disclosure of Survey Results.*—No provision.

(17) *Denial of Payment of Legal Fees for Frivolous Litigation.*—No provision.

(18) *Standards for Certain Professional Services.*—Requires the Secretary to conduct a study on the hiring and dismissal practices of nursing facilities with respect to social workers, dietitians, activities professionals, and medical records practitioners, and report to Congress by January 1, 1993, on whether facilities have on their staffs persons with significantly different credentials as a result of new regulations that became effective October 1, 1990, and the impact of staff composition on quality of care.

(19) *Ombudsman Program Coordination with State Medicaid and Survey and Certification Agencies.*—Requires that State survey agencies enter into a written agreement with the Office of the State Long-Term Care Ombudsman (as defined by the Older Americans Act) to provide for information exchange, case referral, and prompt notification of the office of any adverse action to be taken against a nursing facility.

Effective date: Effective April 1, 1991; except that (a)(1), (a)(4), (a)(6), (b)(1), (b)(2), (b)(7), (c), (d)(3), (d), (d)(18) effective as if included in OBRA 87.

Conference agreement

6. Nursing Home Reform Provisions.—

The managers note that the amendments included below make minor and technical changes to the nursing home reform statute as originally enacted in 1987. The managers are aware that the Secre-

tary will soon issue regulations implementing portions of the original law. The managers do not intend that the amendments below result in any further delay of forthcoming regulations.

(a) Nurse Aide Training.—

*(1) No Compliance Actions Before Effective Date of Guidelines.—*The conference agreement includes the House bill.

*(2) Clarification of Grace Period for Nurse Training of Individuals.—*The conference agreement includes the Senate amendment, with a modification to provide that NFs may not use individuals as nurse aides on a temporary, per diem, leased, or any other basis other than as a permanent employee, on or after January 1, 1991, unless the individual meets the training and competency evaluation requirements that apply to full-time aides.

*(3) Clarification of Nurse Aides Not Subject to Charges.—*The conference agreement includes the House bill, with a modification to specify that the prohibition on charging aides would apply to aides who are employed by or who have received an offer of employment from a facility. The conference agreement also includes an amendment requiring States to provide for the reimbursement of the costs incurred by persons in completing nurse aide training and competency evaluation programs, if they are not employed by or have not received an offer of employment from a facility. These costs would be reimbursed for aides employed within 12 months after completing a program and would be prorated during the period the aide is employed by the facility.

*(4) Modification of Nursing Facility Deficiency Standards.—*The conference agreement includes the House bill, with an amendment. The agreement prohibits the approval of nurse aide training and competency evaluation programs offered by or in a nursing facility which, within the previous 2 years—(a) has had a waiver of the licensed nurse or registered nurse requirements for a period in excess of 48 hours during the week; (b) has been subject to an extended (or partial extended) survey under Medicare or Medicaid; or (c) has been subject to sanctions that may be imposed under Medicare or Medicaid law, including a civil money penalty of not less than \$5,000, denial of payment, appointment of temporary management, closing the facility or transferring residents, or termination. For the 2-year period beginning October 1, 1988, the conference agreement also prohibits the approval of nurse aide training and competency evaluation programs offered by or in a nursing facility which (a) has been terminated from participation in Medicare or Medicaid; or (b) has been subject to sanctions that may be imposed under Medicaid or Medicare or applicable State law, including denial of payment, a civil money penalty of not less than \$5,000, appointment of temporary management, or closing the facility or transferring residents.

*(5) Clarification of State Responsibility to Determine Competency.—*The conference agreement includes the Senate amendment.

*(6) Extension of Enhanced Match Rate Until October 1, 1990.—*The conference agreement includes the Senate amendment.

*(7) Nurse Aide Registry.—*The conference agreement includes the House bill, with an amendment to include on a State's nurse aide registry aides for whom the State may waive the competency evaluation requirements under OBRA 89. The conference agreement

also includes an amendment requiring facilities to consult any State nurse aide registry that the facility believes will include information about an aide.

(8) *Retraining of Nurse Aides Not Employed.*—The conference agreement includes the Senate amendment.

(b) *Preadmission Screening and Annual Resident Review.*—

(1) *No Compliance Actions Before Effective Date of Guidelines.*—The conference agreement includes the House bill.

(2) *Clarification with respect to Admissions and Readmission from a Hospital.*—The conference agreement includes the Senate amendment.

(3) *Delay in Application to Private Pay Residents.*—The conference agreement does not include the House bill.

(4) *Denial of Payments for Certain Residents Not Requiring Nursing Facility Services.*—The conference agreement includes the House bill.

(5) *No Delegation of Authority to Conduct Screening and Reviews.*—The conference includes the Senate amendment.

(6) *Annual Reports.*—The conference agreement includes the Senate amendment.

(7) *Revision of Alternative Disposition Plans.*—The conference agreement includes the House bill.

(8) *Definition of Mentally Ill.*—The conference agreement includes the Senate amendment.

(9) *Substitution of "Specialized Services" for "Active Treatment".*—The conference agreement includes the Senate amendment.

(c) *Enforcement Process.*—The conference agreement includes the House bill.

(d) *Supervision of Health Care of Residents of Nursing Facilities by Nurse Practitioners and Clinical Nurse Specialists Acting in Collaboration with Physicians.*—The conference agreement includes the House bill, with an amendment to include physician assistants, together with nurse practitioners and clinical nurse specialists, as health professionals permitted to supervise the medical care of residents.

(e) *Other Amendments.*—

(1) *Assurance of Appropriate Payment Amounts.*—The conference agreement includes the House bill.

(2) *Disclosure of Information of Quality Assessment and Assurance Committees.*—The conference agreement includes the House bill.

(3) *Period for Resident Assessment.*—The conference agreement includes the Senate amendment.

(4) *Clarification of Responsibility for Services for Mentally Ill and Mentally Retarded Residents.*—The conference agreement includes the House bill.

(5) *Clarification of Extent of State Waiver Authority.*—The conference agreement includes the House bill, with an amendment. The conference agreement requires the State agency granting a waiver to provide notice of the waiver to the State long-term care ombudsman and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and further requires the facility to notify residents (or, where appropriate, the

guardians or legal representatives of residents) and members of their immediate families of the waiver. The conference agreement also requires the Secretary to conduct a study and report to Congress by January 1, 1992, on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for SNFs and NFs, and to include recommendations for appropriate minimum ratios.

(6) *Clarification of Definition of Nurse Aide.*—The conference agreement includes the House bill.

(7) *Clarification of Requirements for Social Services.*—The conference agreement does not include the House bill.

(8) *Charges Applicable in Cases of Certain Medicaid-Eligible Individuals.*—The conference includes the House bill.

(9) *Residents' Rights to Refuse Transfers.*—The conference agreement includes the House bill.

(10) *Residents' Rights Regarding Advance Directives.*—The conference agreement does not include the House bill.

(11) *Resident Access to Clinical Records.*—The conference agreement includes the House bill, with a modification requiring that access to records be provided within 24 hours (excluding hours during a week-end or holiday) after a request. The conference agreement also includes an amendment requiring that access be provided to the resident's legal representative.

(12) *Inclusion of State Notice of Rights in Facility Notice of Rights.*—The conference agreement includes the House bill.

(13) *Removal of Duplicative Qualifications of Nursing Home Administrators.*—The conference agreement includes the House bill, with an amendment that current law requirements would not be repealed until the date upon which the Secretary issues standards specifying qualifications for nursing facility administrators.

(14) *Clarification of Nurse Aide Registry Requirements.*—The conference agreement includes the House bill, with an amendment to include on a State's nurse aide registry aides for whom the State may waive the competency evaluation requirements under OBRA 89. The conference agreement also includes an amendment requiring facilities to consult any State nurse aide registry that the facility believes will include information about an aide.

(15) *Clarification of Findings of Neglect.*—The conference agreement includes the House bill.

(16) *Timing of Public Disclosure of Survey Results.*—The conference agreement includes the House bill.

(17) *Denial of Payment of Legal Fees for Frivolous Litigation.*—The conference agreement includes the House bill.

(18) *Standards for Certain Professional Services.*—The conference agreement includes the Senate amendment, with an amendment to require that any regulations promulgated by the Secretary on medically-related social services, dietary services, and an on-going program of activities include requirements that are at least as strict as those applicable to providers of these services prior to the enactment of OBRA 87. The agreement also deletes the requirement for the Secretary to conduct a study on the hiring and dismissal practices of nursing facilities with respect to social workers, dietitians, activities professionals, and medical records practitioners.

(19) *Ombudsman Program Coordination with State Medicaid and Survey and Certification Agencies.*—The conference agreement includes the Senate amendment, with an amendment to require State survey agencies to notify the Office of the State Long-Term Care Ombudsman of any adverse action taken against a facility under the enforcement section of nursing home reform law.

7. *Home and Community-Based Care Services (Section 6241 of Senate amendment)*

Present law

Under special waiver authorities (sections 1915(c) and 1915(d) of Medicaid law), States may cover a variety of home and community-based long-term care services for elderly persons who would otherwise require institutional care whose cost could be reimbursed by Medicaid. States define the services they wish to cover for a targeted population from a broad range of medical and nonmedical social services that are specified in law. These include case management, homemaker/home health aide services, personal care, adult day health, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based setting. States may provide such services, however, only after they have demonstrated to the Secretary of HHS that coverage of these services would be budget neutral.

House bill

No provision.

Senate amendment

(a) *Home and Community Care as an Optional, Statewide Service.*—Establishes "home and community care for functionally disabled elderly individuals" as a new optional service that States may cover under their Medicaid plans without demonstrating budget neutrality.

(b) *Home and Community Care Defined.*—Defines "home and community care" as one or more of the following services furnished, according to an individual community care plan, to an individual who has been determined, after an assessment, to be a functionally disabled elderly individual: (1) homemaker/home health aide services; (2) chore services; (3) personal care services; (4) nursing care services provided by, or under the supervision of, a registered nurse; (5) respite care; (6) training for family members in managing the individual; (7) adult day health services; (8) in the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility); (9) such other home and community-based services (other than room and board) as the Secretary may approve.

(c) *Functionally Disabled Elderly Individual Defined.*—Defines an eligible "functionally disabled elderly individual" as a person who (1) is 65 years of age or older; (2) is determined to be functionally disabled; and (3) is eligible for Medicaid in the community because of low income and resources or, at the option of the State,

because of large medical expenses (that result in a person "spending down" to qualify as "medically needy"). Provides that States may use a 6-month period for projecting medical expenses and income, in determining eligibility of medically needy persons for optional home and community care services.

In the event that a State discontinues a 1915(c) or 1915(d) waiver, specifies that States would be able to continue to cover under the optional home and community care benefit those elderly persons who received home and community-based services under these waivers, so long as they would be eligible for home and community care benefits, except for the income and resources standards used in the State for determining eligibility for persons living in the community. Allows Texas, which is providing personal care services to functionally disabled persons under a special demonstration project waiver authority (section 1115 of the Social Security Act), to extend home and community care services to aged and disabled persons who meet the waiver's test of functional disability and who meet the State's higher institutional income standard.

(d) Functional Disability Defined.—Defines as "functionally disabled" persons who (1) are unable to perform without substantial assistance from another individual at least 2 of the following 3 activities of daily living (ADLs): toileting, transferring, and eating; or (2) have a primary or secondary diagnosis of Alzheimer's disease and are (a) unable to perform without substantial human assistance (including verbal reminding or physical cuing) or supervision at least 2 of the following 5 ADLs: bathing, dressing, toileting, transferring, and eating; or (b) cognitively impaired so as to require substantial supervision from another individual because the individual engages in inappropriate behaviors that pose serious health or safety hazards to himself or herself or others.

(e) Assessments of Functional Disability.—Requires States, upon the request of an elderly person eligible for Medicaid (or another person on the individual's behalf), to provide for a comprehensive functional assessment to determine whether or not an individual is functionally disabled. Requires that the assessment be based on a uniform minimum data set specified by the Secretary and be conducted using an instrument specified by the State and developed or approved by the Secretary. Provides that no fee may be charged for the assessment.

(1) Specification of Assessment Data Set and Instruments.—By July 1, 1991, requires the Secretary to specify a minimum data set of core elements and common definitions for use in conducting assessments and to establish guidelines for use of the data set. Also requires the Secretary, by July 1, 1991, to designate one or more instruments for use by a State in conducting comprehensive functional assessments. Requires that States use one of the instruments designated by the Secretary or an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines.

(2) Periodic Review.—Requires that individuals qualifying for home and community care services have their assessments periodically reviewed and revised not less often than once every 12 months.

(3) *Conduct of Assessment by Interdisciplinary Teams.*—Requires that assessments and reviews be conducted by an interdisciplinary team designated by the State. Requires that the Secretary permit a State to provide for assessments and reviews through teams under contracts with public organizations or with nonpublic organizations which do not provide home and community care or nursing facilities and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing services.

Requires that interdisciplinary teams (1) identify functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system, and (2) determine, on the basis of the assessment or review, whether the individual is (or continues to be) functionally disabled. Requires that the results of an assessment or review be used in establishing, reviewing, and revising the individual's community care plan.

(4) *Appeals Procedures.*—Requires that each State electing to cover home and community care services as an optional benefit have in effect an appeals process for individuals adversely affected by eligibility determinations of the interdisciplinary team.

(f) *Individual Community Care Plan (ICCP).*—Requires that home and community care be provided according to an individual community care plan (ICCP). Defines an "ICCP" as a written plan which (1) is established and periodically reviewed and revised by a qualified case manager after a face-to-face interview with the individual or primary caregiver and is based on the most recent comprehensive functional assessment of the individual; (2) specifies the home and community care to be provided, within any amount, duration, and scope limitations imposed on care covered under the State Medicaid plan, and indicates the individual's preferences for the types and providers of services; and (3) may specify other services required by the individual. Specifies that an ICCP may also designate the specific providers (qualified to provide home and community care) which will provide care described in the plan.

(1) *Qualified Case Management Entity Defined.*—Defines a "qualified case management entity" as a nonprofit or public agency or organization which (a) has experience or has been trained in establishing, periodically reviewing, and revising ICCPs and in providing case management services to the elderly; (b) is responsible for assuring that home and community care covered under the State plan and specified in the ICCP is being provided, for visiting each individual's home or community setting where care is being provided not less often than once every 90 days, and for informing the elderly individual or primary caregiver on how to contact the case manager if service providers fail to provide services properly or other similar problems occur; (c) in the case of a nonpublic agency, does not provide home and community care or nursing facility services, and does not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides, home and community care or nursing facility services; (d) has procedures for assuring the quality of case management services that includes a peer review process; (e) completes the ICCP in a timely manner and reviews and discusses new

and revised ICCPs with elderly individuals or primary caregivers; and meets other standards established by the Secretary to assure that the case manager is competent to perform case management functions and that individuals whose care they manage are not at risk of financial exploitation due to the manager; and (f) meets other standards established by the State.

(2) *Appeals Process.*—Requires States to have in effect an appeals process for individuals who disagree with their ICCP.

(g) *Ceiling on Payment Amounts and Maintenance of Effort.*—

(1) *Ceiling on Payment Amounts.*—Specifies that Federal Medicaid matching payments to a State for home and community care provided in any calendar quarter could not exceed 50 percent of the product of the following: (1) the average number of individuals receiving care in the quarter, (2) the average per diem rate of payment for Medicare skilled nursing facility care in that State for the quarter, and (3) the number of days in the quarter.

(2) *Maintenance of Effort.*—Requires States covering home and community care to report to the Secretary, in a format developed or approved by the Secretary, the amount of funds obligated by the State (including its localities) for the provision of home and community care to functionally disabled elderly individuals in each Federal fiscal year (beginning with FY 1990). If the amount spent by a State in any future fiscal year is less than the amount spent in 1989 requires the Secretary to reduce Federal matching payments to the State by the difference between the amounts.

(h) *Minimum Requirements for Home and Community Care.*—Requires that home and community care meet requirements for individuals' rights and quality published or developed by the Secretary, including (1) a requirement that individuals providing community care are competent to provide care; (2) specification of individuals' rights. Rights include the following: (1) the right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except for an individual determined incompetent) to participate in planning care or changes in care; (2) the right to voice grievances about services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State or local authorities; (3) the right to confidentiality of personal and clinical records; (4) the right to privacy and to have one's property treated with respect; (5) the right to refuse all or part of any care and to be informed of the likely consequences of such refusal; (6) the right to education or training for oneself and for members of one's family or household on the management of care; (7) the right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual's ICCP; (8) the right to be fully informed orally and in writing of the individual's rights; and (9) any other rights established by the Secretary.

(i) *Minimum Requirements for Small Community Care Settings.*—Requires that small community care settings in which home and community care is provided meet certain requirements.

(1) *Small Community Care Settings Defined.*—Defines "small community care setting" as (a) a nonresidential setting that serves

more than 2 and less than 8 individuals, or (b) a residential setting in which more than 2 and less than 8 unrelated adults reside and in which personal services (other than merely board) are provided.

(2) *Minimum Requirements.*—Provides that a small community care setting in which home and community care is provided must meet certain requirements, including requirements (1) published or developed by the Secretary as provided below; (2) relating to individuals' rights as specified in Medicaid law for nursing facility residents, to the extent applicable to the setting; (3) for informing individuals, orally and in writing, of their legal rights; (4) for meeting any applicable State or local requirements regarding certification or licensure; (5) for meeting any applicable State and local zoning, building, and housing codes, and State and local fire and safety regulations; and (6) for being designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents.

(j) *Minimum Requirements for Large Community Care Settings.*—Requires that large community care settings in which home and community care is provided meet certain requirements.

(1) *Large Community Care Setting Defined.*—Defines "large community care setting" as (a) a nonresidential setting in which more than 8 individuals are served; (b) a residential setting in which more than 8 unrelated adults reside and in which personal services are provided.

(2) *Minimum Requirements.*—Provides that a large community care setting in which home and community care is provided must meet certain requirements, including requirements (1) published or developed by the Secretary as provided below; (2) relating to individuals' rights as specified in Medicaid law for nursing facility residents, to the extent applicable to the setting; (3) for informing individuals, orally and in writing, of their legal rights; and (4) for meeting certain requirements in Medicaid law relating to administration and other matters for nursing facilities, except that the Secretary must provide for the application of life safety requirements (if any) that are appropriate to the setting.

(3) *Disclosure of Ownership and Control Interests and Exclusion of Repeated Violators.*—Requires that community care settings disclose persons with an ownership or control interest in the setting. Prohibits a community care setting from having as a person with an ownership or control interest any one who has been excluded from participation in Medicaid or who has had an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard or to have failed to meet the minimum requirements for settings specified in this section.

(k) *Survey and Certification Process.*—

(1) *Certifications.*—Requires that States be responsible for certifying the compliance of providers of home and community care and community care settings with the minimum requirements. Provides that the failure of the Secretary to issue regulations for States to carry out these certification requirements shall not relieve a State of its responsibility to do so. Requires the Secretary to be responsible for certifying the compliance of State providers of home and community care and State community care settings with

these same requirements. Requires that certification of providers and settings occur no less frequently than once every 12 months.

(2) *Reviews of Providers.*—Requires that certification of a provider of home and community care be based on a periodic review of the provider's performance in providing care according to the requirements specified in law. Provides that if the Secretary has reason to question the compliance of a provider of home and community care with the requirements, the Secretary may conduct a review of the provider and, on the basis of that review, make independent and binding determinations concerning the extent to which the provider meets the requirements.

(3) *Surveys of Community Care Settings.*—Requires that certification of community care settings be based on a survey conducted without prior notice. Authorizes a civil money penalty of up to \$2,000 for persons who notify a community care setting of the time or date of the survey and requires the Secretary to review each State's procedures for avoiding giving notice of surveys. Requires that surveys be based on a protocol developed by the Secretary. Prohibits the use on survey teams of persons who are serving (or have served within the previous 2 years) as members of the staff of, or as consultants to, the community care setting being surveyed (or the persons responsible for the setting), or who have a personal or familial financial interest in the setting. Provides that if the Secretary has reason to question the compliance of a setting with the certification requirements, the Secretary may conduct a survey of the setting, and on the basis of the survey, make independent and binding determinations about the extent to which the setting meets the requirements.

(4) *Investigation of Complaints and Monitoring of Providers and Settings.*—Requires the States and the Secretary to maintain procedures and adequate staff to investigate complaints of violations of certification requirements for providers of community care and community care settings.

(5) *Investigation of Allegations of Individual Neglect and Abuse and Misappropriation of Individual Property.*—Requires States to provide for a process for receiving, reviewing, and investigating allegations of individual neglect and abuse (including injuries of unknown source) and misappropriation of individual property. Requires States to provide for documentation of findings relating to these allegations, for including any brief statement of the individual disputing the findings, and for including in any disclosure of findings the brief statement (or a clear and accurate summary thereof).

(6) *Disclosure of Results of Inspections and Activities.*—Requires the States and the Secretary to make available to the public information on all surveys, reviews, and certifications, including statements of deficiencies; copies of cost reports (if any) of providers and settings; copies of statements of ownership, and information about owners and other persons convicted of certain offenses. Requires the State make a reasonable effort to notify promptly an individual receiving care and an immediate family member of a finding of substandard care. Requires States to provide its Medicaid fraud and abuse control unit with access to information of the State agency responsible for surveys, reviews, and certifications.

(1) Enforcement Process for Providers of Community Care.—

(1) State Authority.—Provides that if a State finds that a provider of home or community care no longer meets the requirements of law, the State may terminate the provider's participation in Medicaid and may provide, in addition, for a civil money penalty. Provides that if the State finds that a provider meets the requirements but, as of a previous period, did not meet them, the State may provide for a civil money penalty for the period during which the provider was not in compliance. Specifies that these provisions shall not restrict the remedies available to a State to remedy a provider's deficiencies.

Requires States to establish by law (whether statute or regulation) at least a civil money penalty remedy, assessed and collected with interest for each day the provider is out of compliance with the requirements of law. Provides that the funds collected by a State as a result of imposition of the penalty may be applied to reimbursement of individuals for personal funds lost due to a failure of home or community care providers to meet the requirements. Requires States to specify criteria as to when and how this remedy is to be applied and the amounts of any penalties. Requires that these criteria be designed to minimize the time between the identification of violations and final imposition of the penalties and provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies. Requires that States electing to provide home and community care establish the above civil money penalty remedy. Requires the Secretary to provide, through regulations or otherwise, by not later than July 1, 1990, guidance to the States for establishing this remedy, but the failure of the Secretary to provide this guidance would not relieve a State of its responsibility for establishing the remedy.

(2) Secretarial Authority.—Provides the Secretary with the authority and duties of a State with regard to a State provider of home or community care, except for different specifications for civil money penalties described below. For any other provider of home or community care in a State, provides that if the Secretary finds that a provider no longer meets a certification requirement, the Secretary may terminate the provider's participation under the State plan and may provide, in addition, for a civil money penalty described below. Further provides that if the Secretary finds that a provider meets the requirements but, as of a previous period, did not meet them, the Secretary may provide for a civil money penalty for the period during which the provider was not in compliance.

Requires the Secretary to impose a civil money penalty in an amount not to exceed \$10,000 for each day of noncompliance with the requirements. Requires the Secretary to specify criteria as to when and how this remedy is to be applied and the amounts of any penalties. Requires that these criteria be designed to minimize the time between the identification of violations and final imposition of the penalties and provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies.

(m) Secretarial Responsibilities.—Requires the Secretary to publish by December 1, 1991, a proposed regulation that sets forth requirements for home and community care and for community care settings, including regulations for functional assessments, qualifica-

tions for case managers, minimum requirements for home and community care, minimum requirements for small and large community care settings, and survey protocols. Requires the Secretary to develop final requirements, and survey protocols and methods for evaluating and assuring the quality of community care settings, by October 1, 1992. Provides that interim and final requirements assure, through methods other than reliance on State licensure processes, that individuals receiving home and community care are protected from neglect, physical and sexual abuse, financial exploitation, inappropriate involuntary restraint, and the provision of health care services by unqualified personnel in community care settings. Provides that the Secretary may, from time to time, revise the requirements, protocols, and methods. Requires that the Secretary's authority not be delegated to the States. Specifies that States could impose requirements that are more stringent than the requirements published or developed by the Secretary.

(n) *Deeming and Waiver*.—Provides that area agencies on aging as defined in the Older Americans Act (P.L. 100-175) are considered public agencies for purposes of these amendments. Authorizes States to waive the requirement that a nonpublic agency not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services for nonprofit agencies located in areas that are not urbanized areas (as defined by the Bureau of the Census). Also authorizes States to waive the Medicaid statewideness requirement for a program of home and community care provided under this section.

(o) *Limitation on Amount of Expenditures as Medical Assistance*.—Limits funds that may be expended as medical assistance for home and community care as an optional service to \$10 million for FY91, \$20 million for FY92, \$40 million for FY93, \$70 million for FY94, and such sums as provided by Congress for fiscal years thereafter. Provides that these funds be allocated to each State in the proportion of the amount of Federal expenditures made available to the State for FY89 (as reported on line 6 of the four quarterly form HCFA-64 expenditure reports) to the sum of Federal expenditures for all States, excluding the territories.

(p) *Payment for Home and Community Care*.—Requires States to pay for home and community care at rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Amends Medicaid law (clarification of flexibility for State payments of inpatient hospital services) to specify that the Secretary could not limit the amount of payment that may be made for home and community care.

Prohibits Federal Medicaid matching payments from being used to pay for the costs of a civil money penalty or for the legal expenses in defense of a civil money penalty or for exclusion from the program, if there is no reasonable legal ground for the provider's case.

(q) *Conforming Amendments.*—Makes a number of conforming amendments in Medicaid law to accommodate the new home and community care optional benefit.

Effective date: Applies to home and community care furnished on or after July 1, 1991, without regard to whether or not final regulations have been promulgated by that date. Amendments pertaining to payments for home and community care apply to home and community care furnished on or after July 1, 1991, or 30 days after the date of publication of interim regulations of the Secretary setting forth minimum requirements for home and community care providers and for community care settings. Amendment prohibiting Federal matching payments for civil money penalties and legal expenses for these penalties, effective for penalties imposed after the date of enactment. Waives the application of the Paperwork Reduction Act and Executive order 12291 to regulations required for implementing home and community care as an optional service.

Conference agreement

7. *Home and Community-Based Care Services.*—The conference agreement includes the Senate amendment, with an amendment to increase the cap on expenditures to \$580 million over 5 years (\$40 in FY91, \$70 in FY92, \$130 in FY93, \$160 in FY94, and \$180 in FY95).

8. *Community Supported Living Arrangements Services (Section 6242 of the Senate bill)*

Present law

(a) *Provision as Optional Service.*—Medicaid law provides only limited coverage for home and community-based care for persons with mental retardation or related conditions: (1) under the 1915(c) waiver, States may cover habilitation and other community-based services, on a budget neutral basis, to persons at risk of institutionalization; (2) under the case management option, States may target case management services in designated areas; (3) some States use certain optional services, such as “other rehabilitative services” and “personal care services” as a means of offering certain home and community-based services to this population.

(b) *Community Supported Living Arrangements Services.*—There is no current law definition comparable to “community supported living arrangements services.” However, the Medicaid 1915(c) waiver defines “habilitation services” as services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings, and includes prevocational, educational, and supported employment services. The term “habilitation services” does not include special education and related services and vocational rehabilitation services otherwise available under other Federal programs.

(c) *Developmentally Disabled Individual.*—Persons with mental retardation qualify for Medicaid on the basis of being disabled under the Federal Supplemental Security Income program (except in certain States using more restrictive standards), and meeting Medicaid income and resource eligibility standards. Persons with

conditions related to mental retardation are defined in regulation as individuals who have a severe, chronic disability that is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation. The condition must result in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and must require treatment or services similar to those needed by such persons. The condition must be manifest prior to age 22, be likely to continue indefinitely, and result in substantial functional limitations.

(d) *Integrated Living Environment*.—No provision.

(e) *Participating States*.—No provision.

(f) *Quality Assurance*.—Under their 1915(c) waivers, States must provide assurances that necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services. For other noninstitutional providers of Medicaid covered services, States generally follow their own procedures for certifying that providers deliver quality care. Ordinarily the State Medicaid agency relies on findings of the applicable licensing agency or board for the particular provider.

(g) *Maintenance of Effort*.—No provision.

(h) *Waiver of Requirements*.—A waiver granted under section 1915(c) may include a waiver of comparability of amount, duration, and scope of services; statewideness; and income and resource rules.

(i) *Treatment of Funds*.—No provision.

(j) *Limitations on Expenditures*.—No provision.

House bill

No provision.

Senate amendment

(a) *Provision as Optional Service*.—Establishes “community supported living arrangements services” as a new optional service that from 4 to 8 participating States may cover under their Medicaid plans on a limited basis for the first 5 years of the program. The service is limited to developmentally disabled individuals without regard to whether such individuals are at risk of institutionalization.

(b) *Community Supported Living Arrangements Services*.—Defines “community supported living arrangements services” to mean one or more of the following services designed to assist an individual in activities of daily living necessary to permit such individual to live in an integrated living environment. Services may include personal assistance; training and habilitation services (necessary to assist the individual in achieving increased integration, independence, and productivity); 24-hour emergency assistance; assistive technology; adaptive equipment; and other nonexcluded services as approved by the Secretary. Excluded services are room and board, and the cost of prevocational, vocational, and supported employment services.

(c) *Developmentally Disabled Individual*.—The term “developmentally disabled individual” means an individual defined by the

Secretary within the term "mental retardation and related conditions" as defined in regulations in effect on July 1, 1990. In addition, the individual must be residing with the individual's family or legal guardian or in an integrated living environment in which no more than 3 other recipients of services under this section are residing, without regard to whether the individual is at risk of institutionalization.

(d) *Integrated Living Environment*.—Defines the term "integrated living environment" to mean an environment located in a neighborhood which is representative of residential neighborhoods in the community and is populated primarily by individuals other than developmentally disabled individuals.

(e) *Participating States*.—Requires the Secretary to develop criteria for the review of applications from States requesting funds to provide community supported living arrangements services. Requires that during the first 5 years of the provision of services, no less than 4 and no more than 8 States are allowed to participate in this program.

(f) *Quality Assurance*.—Requires participating States to establish and maintain a quality assurance program under which providers of service are certified and surveyed using standards that include minimum qualifications and training requirements for staff, financial operating standards, and a consumer grievance process. Requires States to establish monitoring boards consisting of providers, family members, consumers, and neighbors, and to establish reporting procedures to make information available to the public. Requires States to provide for public hearings on the quality assurance plan prior to its adoption and implementation.

(g) *Maintenance of Effort*.—Requires States providing community supported living arrangements services to maintain current levels of spending for such services to be eligible for participation.

(h) *Waiver of Requirements*.—Allows the Secretary to waive comparability of amount, duration, and scope of services; statewide-ness; freedom of choice of providers; and other Medicaid requirements as needed to carry out the provisions of this section.

(i) *Treatment of Funds*.—Requires that funds expended under this section be in addition to funds expended for any existing Medicaid service, including any waiver services, for which the individual receiving services under this programs is already eligible.

(j) *Limitations on Expenditures*.—Limits the amount of funds that may be expended to carry out the purposes of this section to \$5,000,000 for FY 1991; \$10,000,000 for FY 1992; \$20,000,000 for FY 1993; \$35,000,000 for FY 1994; and such sums as provided by Congress for fiscal years thereafter.

Effective Date: July 1, 1991, regardless of whether final regulations have been promulgated by such date. Requires the Secretary to provide that the required applications are received from the States and approved prior to the effective date.

Conference agreement

8. *Community Supported Living Arrangements Services*.—The conference agreement includes the Senate amendment, with an amendment that caps expenditures at \$100 million, provides that the applicable number of residents who are recipients of this serv-

ice shall be 3 or fewer, requires that a State amendment must be reviewed by the State Planning Council and the Protection and Advocacy System established under section 124 and section 142, respectively, of the Developmental Disabilities Assistance and Bill of Rights Act, and specifies that payment for quality assurance functions shall be eligible for Federal matching funds. The agreement also provides for an Individual Support Plan that outlines individual needs and the activities necessary to assist the individual, and clarifies that the prohibition on payments for room and board excludes the portion of costs for rent and food attributable to an unrelated caregiver residing in the household.

9. Miscellaneous Provisions Relating to Payments (Sections 4441-4448 of the House bill, sections 6122(b), 6268, 6274, and 6275 of the Senate amendment)

Present law

(a) State Medicaid Matching Payments through Voluntary Contributions and State Taxes.—States must contribute from 17 to 50 percent of the costs of providing Medicaid benefits; the State share rises in proportion to the State's per capita income. (A portion of this responsibility may be passed on to localities.) Some States finance part of the State share of Medicaid costs through voluntary donations of funds by hospitals participating in the program. Other States have used dedicated taxes imposed on hospital revenues. The Administration contested some of these State actions in administrative proceedings and indicated its intention to modify Medicaid regulations to change the treatment of voluntary contributions or provider-paid taxes used by States to claim Federal matching funds. The Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647) prohibited the Secretary from issuing final regulations in this matter before May 1, 1989. OBRA 89 (P.L. 101-239) extended the moratorium to December 31, 1990. In February, 1990, the Administration published proposed regulations that would restrict Federal matching funds for portions of the State share that result from provider donations or taxes applied uniquely to providers.

(b) Disproportionate Share Hospitals.—

(1) Clarification of Calculation of Adjustment for Disproportionate Share Hospitals.—States are required to make additional payments for inpatient services to hospitals serving a disproportionate number of low-income patients with special needs. A hospital may qualify for the payment adjustments if its Medicaid inpatient utilization rate is at least one standard deviation above the mean rate for all Medicaid-participating hospitals in the State; the rate is calculated as Medicaid inpatient days divided by total inpatient days. (A hospital may instead qualify on the basis of its "low-income utilization rate"; see item (3) below.)

(2) Federal Financial Participation for Medicaid Capital Payments.—The Secretary is prohibited from limiting the amount of payment adjustments made by States to disproportionate share hospitals.

(3) Disproportionate Share Formula.—The statute currently specifies two ways that a State can compute the amount of additional

payment to be made to disproportionate share hospitals, one which follows the comparable calculation under Medicare, and one that increases payments proportionately to the amount by which a hospital's Medicaid utilization rate exceeds one standard deviation above the mean Medicaid utilization rate for participating hospitals in the State. In an initial instruction to States, the Secretary allowed States to use some other method (such as one that varied payment adjustments by type of hospital) if aggregate payment adjustments would be at least as much as would have been made under one of the statutory options. This third option would be eliminated under proposed regulations published by the Secretary on March 19, 1990.

(4) *Clarification of Special Rule for State Using Health Insuring Organization.*—OBRA 1987, as amended by MCCA, provided that, for the three years beginning July 1, 1988, a State using a health insuring organization (HIO) to administer part of its program on a statewide basis could use an alternate system for classifying hospitals as disproportionate share hospitals and computing payment adjustments, so long as the aggregate adjustments were at least equal to what would otherwise have been payable under Medicaid law, and provided that disproportionate share hospitals assured the availability of Medicaid-participating obstetricians at rural as well as urban hospitals.

(5) *Minimum Payment Adjustment for Certain Hospitals.*—No provision.

(6) *Payment on the Basis of Low-Income Utilization Rate.*—A hospital may qualify as a disproportionate share hospital if its low-income utilization rate exceeds 25 percent. (The calculation of the low-income utilization rate takes into account a hospital's dependence on Medicaid and State and local indigent care funding and the amount of charity care it furnishes.) The amount of payment adjustment for such a hospital is computed in the same way as the adjustment for a hospital qualifying on the basis of Medicaid utilization alone.

(c) *Federally Qualified Health Centers.*—OBRA 1989 requires States to include in their Medicaid benefit packages services furnished by federally qualified health centers, and to pay the centers 100 percent of their reasonable costs. "Federally qualified health center" means a facility which is receiving a grant under section 329, 330, or 340 of the Public Health Service Act, or is determined to meet the requirements for such a grant.

(d) *Hospice Payments.*—States may cover under their Medicaid programs hospice care as an optional benefit for terminally ill individuals who voluntarily elect to receive hospice care in lieu of certain other benefits. OBRA 89 required States to pay hospices for Medicaid eligible nursing home residents electing hospice an additional amount (to take into account the room and board furnished by the facility) equal to at least 95 percent of the rate that would have been paid by the State to that facility for the Medicaid beneficiary.

(e) *Limitations on Disallowance of Certain Inpatient Psychiatric Hospital Services.*—In order for psychiatric inpatient care of individuals under age 21 to be covered under Medicaid, a team of physicians and other qualified personnel must certify that the patient

requires inpatient care at the time of admission (or at the time the patient qualifies for Medicaid benefits, if this occurs after admission) and that the services can reasonably be expected to improve the patient's condition to the point at which inpatient care will no longer be necessary. The Secretary has the authority to disallow Federal matching payments to a State for cases in which these certification of need requirements are not met.

(f) *Treatment of Interest on Indiana Disallowance.*—When the Secretary issues a notice of disallowance of Federal Medicaid funds, the State may choose to pay the amount in dispute at once or wait until all appeals have been exhausted. If the State defers payment and the disallowance is affirmed, the State must pay interest on the amount owed to the Federal Government.

(g) *Billing for Services of Substitute Physician.*—States are generally prohibited from issuing Medicaid payment to anyone other than the provider of a service, the provider's employer, or the facility in which the provider furnished the service pursuant to a contractual agreement. There are exceptions for assignment to government agencies, court-ordered assignments, and assignments to collection agents not paid on a contingent or percentage basis.

House bill

(a) *State Medicaid Matching Payments through Voluntary Contributions and State Taxes.*—Permits States to use hospital donations to finance up to 10 percent of the State's share of Medicaid costs in a fiscal year, provided the funds are subject to the unrestricted control of the State and the funds donated by or on behalf of a particular hospital account for no more than 10 percent of the hospital's gross revenues in a year (not counting revenues from Medicare, Medicaid, or the Maternal and Child Health block grant). Provides that a transfer of funds from a hospital to a State may be regarded as a donation even if the hospital benefits from it, unless the benefit is directly related to the transfer in timing and amount. Prohibits the Secretary from limiting payments to a State on the grounds that State spending was financed by taxes on provider services.

Effective date: The provision relating to donated funds applies to funds donated on or after January 1, 1991; the provision relating to taxes takes effect on January 1, 1991.

(b) *Disproportionate Share Hospitals.*—

(1) *Clarification of Calculation of Adjustment for Disproportionate Share Hospitals.*—Provides that the computation of the Medicaid inpatient utilization rate shall include days spent by patients (including newborns) in specialized wards or while waiting for placement outside the hospital.

(2) *Federal Financial Participation for Medicaid Capital Payments.*—Provides that the prohibition against limitation by the Secretary of payment adjustments to disproportionate share hospitals also applies to pass-through payments for those hospitals' capital costs.

(3) *Disproportionate Share Formula.*—Provides that a State may use an alternative formula that takes into account the characteristics of patients in different categories of disproportionate share hospitals in the State.

(4) *Clarification of Special Rule for State Using Health Insuring Organization.*—Makes permanent the special rule for a State using an HIO.

(5) *Minimum Payment Adjustment for Certain Hospitals.*—Provides for a special minimum disproportionate share payment adjustment for a hospital with a Medicaid inpatient utilization rate of at least 45 percent and in which no more than 8 percent of inpatient days are covered by private insurance, if the hospital is in a health manpower shortage area in a State that has a freedom-of-choice waiver to permit selective contracting for inpatient hospital services. Requires that the additional payment for such a hospital be at least half of the amount paid under the State plan for inpatient operating costs, provided that aggregate Medicaid payments do not exceed the hospital's reasonable costs for providing inpatient and outpatient care to Medicaid beneficiaries.

(6) *Payment on the Basis of Low-Income Utilization Rate.*—No provision.

Effective date: (1) is effective July 1, 1990. (2) is effective as if included in the enactment of OBRA 1981. (3) and (4) are effective as if included in the enactment of OBRA 1987. (5) applies to calendar quarters beginning on or after January 1, 1991, and before October 1, 1993, without regard to whether implementing regulations have been promulgated.

(c) *Federally Qualified Health Centers.*—Requires States to use Medicare payment methodology to reimburse federally qualified health centers (FQHC). Requires State prepaid risk contracts with health maintenance organization be an entity rather than a facility, and to include an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (P.L. 93-638) among entities that are FQHCs.

Effective date: Effective as if included in the enactment of OBRA 1989.

(d) *Hospice Payments.*—Clarifies that the additional amount be paid for dually eligible nursing facility residents electing hospice under Medicare. Makes conforming changes to reflect the elimination of the distinction in Medicaid law between SNFs and ICFs.

Effective date: Effective as if included in OBRA 1989.

(e) *Limitations on Disallowance of Certain Inpatient Psychiatric Hospital Services.*—Applies restrictions to disallowances for failure to comply with certification of need requirements, in cases in which the DHHS Inspector General has initiated or completed review by October 11, 1990, and the disallowance or deferral action has not taken at the time of enactment or has not been the subject of a final judicial determination or administrative decision not subject to judicial review. Limits the time period of a disallowance for any patient to the period between admission and the date on which the facility has developed a plan of care or documented the need for inpatient care. Further limits the disallowance period to three years before the date of the audit that uncovers a violation, and limits the disallowance amount to 25 percent of the Federal payment made for the period of noncompliance.

Effective date: Enactment.

(f) *Treatment of Interest on Indiana Disallowance.*—Provides that, with respect to any disallowance of payments for skilled nurs-

ing or intermediate care facilities (ICFs) or ICFs for the mentally retarded on the grounds that the facilities were not properly certified during the period June 1, 1982, through September 30, 1984, Indiana may defer payment without interest penalty until all appeals have been exhausted.

Effective date: Enactment.

(g) *Billing for Services of Substitute Physician.*—No provision.

Senate amendment

(a) *State Medicaid Matching Payments through Voluntary Contributions and State Taxes.*—Continues the moratorium on regulations pertaining to voluntary contributions and provider-specific taxes until September 1, 1991.

Effective date: Enactment.

(b) *Disproportionate Share Hospitals.*—

(1) *Clarification of Calculation of Adjustment for Disproportionate Share Hospitals.*—No provision.

(2) *Federal Financial Participation for Medicaid Capital Payments.*—No provision.

(3) *Disproportionate Share Formula.*—Allows States to use criteria other than those set forth in the statute for determining whether a facility qualifies as a disproportionate share hospital, if the criteria were included in a State plan amendment approved by the Secretary before May 1, 1989. Permits States to continue using current methods for computing payment adjustments, provided the amount of each adjustment is reasonably related to services provided to Medicaid or low-income patients and either (A) the amount of each adjustment is at least as great as the amount specified in law or (B) in the case of a State plan approved before December 22, 1987, the aggregate payment adjustments are at least as much as would have been made under one of the statutory options.

(4) *Clarification of Special Rule for State Using Health Insuring Organization.*—No provision.

(5) *Minimum Payment Adjustment for Certain Hospitals.*—No provision.

(6) *Payment on the Basis of Low-Income Utilization Rate.*—Requires that the payment adjustment for a hospital qualifying on the basis of its low-income utilization rate increase in proportion to the amount by which that rate exceeds 25 percent.

Effective date: Enactment.

Federally Qualified Health Centers.—No provision.

(d) *Hospice Payments.*—No provision.

(e) *Limitations on Disallowance of Certain Inpatient Psychiatric Hospital Services.*—Similar provision, except limits the disallowance period to three fiscal years before the fiscal year in which a determination by the Secretary of noncompliance is made.

Effective date: Applies to disallowance actions that are pending or for which there has not been a final judicial decision as of the date of enactment.

(f) *Treatment of Interest on Indiana Disallowance.*—No provision.

(g) *Billing for Services of Substitute Physician.*—Provides that, when one physician's patients are treated by a second physician under an informal reciprocal arrangement (lasting no more than 14 days) or under an arrangement involving per diem or fee-for-

time compensation (for a period of up to 90 days, or longer if provided by the Secretary), payment may be made to the first physician, so long as the claim identifies the physician who actually furnished the service.

Effective date: Applies to services furnished on or after the date of enactment.

Conference agreement

9. Miscellaneous Provisions Relating to Payments.—

(a) *State Medicaid Matching Payments through Voluntary Contributions and State Taxes.*—The conference agreement on voluntary contributions includes the Senate amendment with an amendment to extend the moratorium on final regulations re voluntary contributions to December 31, 1991. The conference agreement on provider-specific taxes includes the House bill with an amendment to exclude taxes from a provider's cost base for purposes of Medicaid reimbursement.

(b) *Disproportionate Share Hospitals.*—The conference agreement includes item (1), (3), and (4) of the House bill, and item (6) of the Senate amendment, with amendments.

(c) *Federally Qualified Health Centers.*—The conference agreement includes the House bill with technical amendments.

(d) *Hospice Payments.*—The conference agreement includes the House bill.

(e) *Limitations on Disallowance of Certain Inpatient Psychiatric Hospital Services.*—The conference agreement includes the Senate amendment.

(f) *Treatment of Interest on Indiana Disallowance.*—The conference agreement includes the House bill.

(g) *Billing for Services of Substitute Physician.*—The conference agreement includes the Senate amendment with an amendment to follow Medicare policy.

10. Miscellaneous Provisions Relating to Eligibility and Coverage (Sections 4451-4458 of the House bill, sections 6243, 6265, 6266, 6267, and 6271 of the Senate amendment)

Present law

(a) *Providing Medical Assistance for Payments for Premiums for COBRA Continuation Coverage Where Cost Effective.*—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), provided that an employer with 20 or more employees that offered a group health plan must offer employees the opportunity to continue coverage under that plan after certain "qualifying events," such as termination of employment, that would ordinarily end the coverage. For most qualifying events, coverage can continue for 18 months, with the employee responsible for the premium (up to 102 percent of the premium otherwise applicable). OBRA 89 allowed an extension of coverage up to 29 months for persons with a disability at the time they terminated employment. For months after the 18th month, the employee's maximum premium is 150 percent of the premium otherwise applicable.

State Medicaid programs are permitted to pay health insurance premiums on behalf of beneficiaries, but only if the beneficiaries meet the financial and other standards for Medicaid eligibility.

(b) *Provisions Relating to Spousal Impoverishment.*—The Medicare Catastrophic Coverage Act included provisions that made major changes in Medicaid's treatment of income and resources of a couple when one member of the couple is in a nursing home and eligible for Medicaid. These provisions addressed "spousal impoverishment" issues and permit the spouse remaining in the community to retain more resources and income than previously had been allowed.

(c) *Disregarding German Reparation Payments from Post-Eligibility Treatment of Income under the Medicaid Program.*—No provision.

(d) *Amendments Relating to Medicaid Transition Provision.*—States are required to continue Medicaid for 6 months after a family loses AFDC benefits because of increased earnings or hours of employment, if the family received AFDC benefits in 3 of the 6 months preceding the termination. The State must offer an additional 6 months of coverage when the initial period ends, subject to an optional premium and other limitations. In order to retain eligibility, the family must report on earnings and child care costs by the 21st day of the 4th, 7th, and 10th months of the extended coverage. The transition coverage provisions, established by the Family Support Act of 1988, expire September 30, 1998.

(e) *Clarifying Effect of Hospice Election.*—Medicaid law requires terminally ill beneficiaries electing hospice to waive payment for services that are determined by the Secretary to be related to the treatment of the individual's terminally ill condition or that are duplicative of hospice care. Medicaid also specifies that election procedures must be consistent with those under Medicare. Medicare does not cover certain non-skilled services that States may cover under their Medicaid programs, e.g., personal care services.

(f) *Clarification of 133 Percent Limit and Clarification of Medically Needy Income Levels.*—

(1) *States may not provide Medicaid to persons with a countable family income greater than 133⅓ percent of the State's maximum AFDC payment for a family of the same size. This restriction does not apply to target groups of pregnant women and children, qualified Medicare beneficiaries, persons receiving or eligible for cash assistance (or who would be eligible if they were not in an institution), and persons in an institution meeting an income standard no higher than 300 percent of the maximum SSI benefit. Although the 133⅓ percent limit has been understood as applying only to the "medically needy", Congress has added a number of additional mandatory or optional Medicaid coverage groups without specifying whether the limit was intended to apply to them.*

(2) *In determining eligibility for the aged, blind, and disabled, section 209(b) States may use more restrictive income and resource standards than those used for SSI. MCCA (P.L. 100-360) provided that 209(b) States may not use more restrictive methodologies in determining income and resources than those used under SSI, but did not modify a conflicting existing provision of law.*

(3) *The income limitation for a medically needy family is 133½ percent of the highest amount which would ordinarily be paid under the State's AFDC plan to a family of the same size without any income or resources. In the case of a one person family, the "highest amount which would ordinarily be paid" is the amount determined by the State (on the basis of reasonable relationship to the amounts payable under AFDC to families of two or more persons) to be payable to a family consisting of one person, without any income or resources, if the State's plan provided for aid to such a family. OBRA 89 prohibits the Secretary from issuing, before December 31, 1990, a final regulation implementing the proposed regulation published on September 26, 1989 (54 Federal Register 39421) insofar as it changes in any way the methods for establishing the medically needy income level for single individuals currently used by any State.*

(g) *Codification of Coverage of Rehabilitation Services.*—Rehabilitative services are among the optional Medicaid benefits States are permitted to offer. Medicaid regulations define these as medical or remedial services recommended by a physician or other licensed practitioner and designed to reduce physical or mental disability and restore an individual to the best possible functional level.

(h) *Personal Care Services.*—Some State Medicaid programs cover personal care services, such as assisting with administration of medications and basic personal hygiene, eating, grooming, and toileting, which can help persons who would otherwise require institutional care to remain at home. Although personal care services are not among the optional Medicaid services included in statute, the Secretary has authorized coverage of personal care services in a beneficiary's home under a general authority to approve the inclusion of additional medical or remedial services in a State Medicaid plan. The services are defined in Medicaid regulations as those provided in a recipient's home provided by a qualified person who is supervised by a registered nurse and who is not a member of the individual's family, pursuant to a plan of treatment prescribed by a physician.

(i) *Medicaid Coverage of Alcoholism and Drug Dependency Treatment Services.*—There is no explicit statutory provision for treatment of alcoholism or drug dependency under Medicaid, although some treatment such as detoxification or methadone maintenance may be provided under physician's, inpatient hospital, clinic, or other covered services. States are permitted to provide Medicaid coverage to individuals under age 21 in psychiatric hospitals, or to individuals over age 65 in institutions for mental diseases (IMDs). However, current law does not allow States to cover individuals who are over age 21 and under age 65 in IMDs.

(j) *Medicaid Spenddown Option.*—States are permitted to provide Medicaid coverage to "medically needy" individuals—persons who fall into one of the categories covered by the State, and whose income and resources are above categorically needy standards but below the medically needy standards established by the State. Many persons become medically needy only after they have incurred medical expenses sufficient to reduce their incomes and/or resources to medically needy levels. This process is known as

spenddown. Individuals may incur regular expenses that make them newly eligible periodically.

(k) Optional State Medicaid Disability Determinations Independent of the Social Security Administration.—A State may choose to contract with the Social Security Administration (SSA) for determinations of eligibility for SSI disability benefits. (Such agreements are authorized by section 1634 of the Social Security Act, and States entering into them are known as section 1634 States.) The State agency may retain the responsibility for determining eligibility for persons who apply only for medical assistance on the basis of disability. A final rule published by the Secretary on December 11, 1989, provides that a section 1634 State cannot make its own determination of disability for Medicaid purposes for an individual whose SSI application is still in process at SSA (unless the period for determining Medicaid eligibility has expired or the individual cites different grounds for disability) or for an individual determined by SSA not to be disabled within the 12-month period before the Medicaid application.

House bill

(a) Providing Medical Assistance for Payments for Premiums for COBRA Continuation Coverage Where Cost Effective.—Allows a State Medicaid program the option of paying COBRA continuation premiums for individuals who are eligible for COBRA coverage, whose family income is no more than 100 percent of the Federal poverty level, and whose resources are no more than twice the limit applicable for SSI in the State, if the State determines that resulting savings in Medicaid costs are likely to exceed the cost of the premiums. Provides that income and resources are to be determined according to the State's methodology for SSI, except that incurred costs for medical or remedial are not to be taken into account.

Effective date: Applies to medical assistance furnished on or after January 1, 1991.

(b) Provisions Relating to Spousal Impoverishment.—Includes clarifying amendments to spousal impoverishment provisions of Medicaid law: Provides that the assessment and allocation of a couple's resources is to occur only at the beginning of the first continuous period of institutionalization beginning after September 30, 1989. Provides clarifications with regard to the non-application of State community property laws and transfer of resources to the community spouse.

Effective date: Effective as if included in the Medicare Catastrophic Coverage Act of 1988.

(c) Disregarding German Reparation Payments from Post-Eligibility Treatment of Income under the Medicaid Program.—Provides that reparation payments made by the Federal Republic of Germany shall be disregarded in determining the income of individuals who are already eligible for Medicaid and who are institutionalized or receiving services under a home and community-based services program.

Effective date: Applies to treatment of income for months beginning more than 30 days after enactment.

(d) Amendments Relating to Medicaid Transition Provision.—Makes the transition coverage provisions permanent. Prohibits a State from requiring reports other than at the specified intervals and allows a State to continue coverage for a family that fails to report if the family establishes to the State's satisfaction that there was good cause for the failure. Provides that a termination for failure to report may not effect until 10 days after notice is mailed.

Effective date: Effective as if included in the enactment of the Family Support Act of 1988.

(e) Clarifying Effect of Hospice Election.—Adds to Medicaid law a clarification that, in electing hospice care, a Medicaid beneficiary waives payment for services for which payment may otherwise be made under Medicare.

Effective date: Enactment.

(f) Clarification of 133 Percent Limit and Clarification of Medically Needy Income Levels.—

(1) Clarifies that the income limit applies only to the "medically needy" (and not to a variety of other optional or mandatory coverage groups not explicitly exempt from the limit under current law).

(2) Modifies the conflicting provision to clarify that methodologies used by section 209(b) States in determining income and resources for the aged, blind, and disabled may be less restrictive, but not more restrictive, than those used under SSI.

(3) Permits a State to base medically needy eligibility for single persons on an AFDC payment standard for a family of two, if the State plan provided for such policy as of June 1, 1989.

Effective date: (1) and (2) Effective as included in the enactment of OBRA 1986. (3) Enactment.

(g) Codification of Coverage of Rehabilitation Services.—Incorporates the regulatory definition in the statute, with minor changes.

Effective date:—Enactment.

(h) Personal Care Services.—Requires that Federal matching payments for Minnesota include payments for personal care, defined as services (1) prescribed by a physician for an individual in accordance with a plan of treatment, (2) provided by a person who is qualified to provide such services who is not a member of the individual's family, (3) supervised by a registered nurse, and (4) furnished in a home or other location; but does not include such services furnished to an inpatient or resident of a hospital or nursing facility.

Effective date.—Enactment and also applies to personal care services furnished before such date pursuant to regulations in effect as of July 1, 1989.

(i) Medicaid Coverage of Alcoholism and Drug Dependency Treatment Services.—No provision.

(j) Medicaid Spenddown Option.—No provision.

(k) Optional State Medicaid Disability Determinations Independent of the Social Security Administration.—No provision.

Senate amendment

(a) Providing Medical Assistance for Payments for Premiums for COBRA Continuation Coverage Where Cost Effective.—

(b) Provisions Relating to Spousal Impoverishment.—No provision.

(c) *Disregarding German Reparation Payments from Post-Eligibility Treatment of Income under the Medicaid Program.*—No provision.

(d) *Amendments Relating to Medicaid Transition Provision.*—No provision.

(e) *Clarifying Effect of Hospice Election.*—No provision.

(f) *Clarification of 133 Percent Limit and Clarification of Medically Needy Income Levels.*—

(1) No provision.

(2) No provision.

(3) Similar provision.

Effective date:—Enactment.

(g) *Codification of Coverage of Rehabilitation Services.*—No provision.

(h) *Personal Care Services.*—Includes in Medicaid's definition of home health services personal care services (1) prescribed by a physician for an individual in accordance with a plan of treatment, (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, (3) supervised by a registered nurse, and (4) furnished in a home or other location; but not including such services furnished to an inpatient or resident of a nursing facility, such as adult day care settings or congregate living arrangements.

Effective date: Effective for home health services provided January 1, 1991, through December 31, 1993.

(i) *Medicaid Coverage of Alcoholism and Drug Dependency Treatment Services.*—Clarifies current policy by amending section 1905(a) of the Social Security Act to prohibit exclusion of a service (including counseling) solely because it is provided as a treatment service for alcoholism or drug dependency.

Effective date: Enactment.

(j) *Medicaid Spenddown Option.*—Permits States to apply an alternative methodology for establishing medically needy eligibility. Medicaid applicants would have the option of establishing eligibility after paying the anticipated amount of regularly incurred expenses to the State, instead of becoming eligible only after incurring expenses. Federal financial participation would be available only for State expenditures in excess of the amount paid in.

Effective date: Enactment.

(k) *Optional State Medicaid Disability Determinations Independent of the Social Security Administration.*—Provides that a State may furnish Medicaid to an otherwise eligible person on the basis of the State's own determination of disability or blindness during the period before SSA makes a final determination of disability or blindness, provided that the State uses the criteria set forth in SSI law. Requires the General Accounting Office to study the appropriateness of using SSI disability and blindness criteria, including durational requirements, for Medicaid eligibility purposes. Requires that a report on the study and any recommendations be submitted to Congress and to the Secretary by January 1, 1992.

Effective date: Enactment.

Conference agreement

10. Miscellaneous Provisions Relating to Eligibility and Coverage.—

(a) *Providing Medical Assistance for Payments for Premiums for COBRA Continuation Coverage Where Cost Effective.*—The conference agreement includes the House bill, with an amendment limiting application of the provision to employers with 75 or more employees.

(b) *Provisions Relating to Spousal Impoverishment.*—The conference agreement includes the House bill.

(c) *Disregarding German Reparation Payments from Post-Eligibility Treatment of Income under the Medicaid Program.*—The conference agreement includes the House bill.

(d) *Amendments Relating to Medicaid Transition Provision.*—The conference agreement does not include the House bill.

(e) *Clarifying Effect of Hospice Election.*—The conference agreement includes the House bill.

(f) *Clarification of 133 Percent Limit and Clarification of Medically Needy Income Levels.*—The conference agreement includes item (3) of the House bill.

(g) *Codification of Coverage of Rehabilitation Services.*—The conference agreement includes the House bill.

(h) *Personal Care Services.*—The conference agreement includes the House bill in fiscal years 1991 through 1994, and the Senate amendment in fiscal year 1995.

(i) *Medicaid Coverage of Alcoholism and Drug Dependency Treatment Services.*—The conference agreement includes the Senate amendment.

(j) *Medicaid Spenddown Option.*—The conference agreement includes the Senate amendment.

(k) *Optional State Medicaid Disability Determinations Independent of the Social Security Administration.*—The conference agreement includes the Senate amendment.

11. Miscellaneous Provisions Relating to Health Maintenance Organizations. (Section 4461 of the House bill, section 6273 of the Senate amendment)

Present law

(a) *Requirements for Risk-Sharing Health Maintenance Organizations Under Medicaid.*—

(1) *HMO Minimum Membership Requirements.*—No provision.

(2) *Application of Minimum Enrollment, Patient Mix, and Financial Solvency Requirements.*—An HMO or similar organization with a risk-sharing contract must generally have an enrolled population of which no more than 75 percent are Medicare or Medicaid beneficiaries; there are exceptions for certain federally funded centers, pre-1970 contractors, and other specified organizations. Organizations that are not federally qualified HMOs (HMOs determined by the Secretary to meet standards set forth in Title XIII of the Public Health Service Act) must also provide adequate assurances against the risk of insolvency and must report to the State on transactions with related entities.

(3) *Prohibition Against Physician Incentive Payments.*—OBRA 1986 prohibited hospitals and health maintenance organizations (HMOs) or similar entities with a risk contract under Medicare or Medicaid from making payments to a physician, directly or indirectly, as an inducement to reduce or limit services provided to beneficiaries or enrollees. For HMOs, the effective date has been delayed until April 1, 1991.

(b) *Special Rules and Medicaid Enrollment Waiver.*—

(1) *Waiver of 75 Percent Rule for Public Entities.*—States may generally enter into Medicaid risk contracts only with HMOs or similar organizations no more than 75 percent of whose enrollment consists of Medicare or Medicaid beneficiaries. The requirement may be modified or waived for an HMO that is a public entity if the Secretary determines that special circumstances warrant the modification and the HMO is making reasonable efforts to enroll persons other than Medicare/Medicaid beneficiaries.

(2) *Extending Special Treatment to Medicare Competitive Medical Plans.*—Medicaid beneficiaries enrolling in federally qualified HMOs (those determined by the Secretary to meet the requirements of Title XIII of the Public Health Service Act) or certain organizations receiving Federal grant funds may be required to remain enrolled for a period of up to 6 months; the State may agree to continue payment to the HMO on behalf of an enrollee for up to 6 months even if the enrollee loses Medicaid eligibility (these provisions are known as “lock-in” and “guaranteed enrollment period,” respectively).

(3) *Automatic 1-month Reenrollment for Short Periods of Ineligibility.*—A Medicaid beneficiary may lose eligibility for a short interval and then be determined eligible again. In some States, if such an individual was enrolled under a Medicaid HMO contract at the time eligibility was terminated, the State will automatically reenroll the individual in the same HMO when eligibility is reestablished. This practice is not explicitly authorized by law.

(4) *Elimination of Provisional Qualification for HMOs.*—Before 1981, States could contract with an HMO only if the HMO was federally qualified or “provisionally qualified,” having applied for Federal qualification and awaiting final determination. OBRA 1981 permitted States to make their own determinations that an HMO was eligible for a contract, rendering the “provisionally qualified” category obsolete.

(5) *Medicaid Enrollment Waiver.*—No provision.

Effective date: Enactment.

(c) *Extension and Expansion of Minnesota Prepaid Medicaid Demonstration Project.*—

(1) *Extends the waiver through June 30, 1996, and permits expansion of the project to other counties if the expansion will not result in greater Medicaid expenditures than would otherwise have been made.*

(2) *No provision.*

Effective date: Enactment.

(d) *Treatment of Dayton Area Health Plan.*—Exempts the Dayton Area Health Plan from the 75 percent Medicare/Medicaid enrollment maximum for the 5-year period beginning on the date the

Secretary granted the plan a Medicaid waiver under section 2175 of OBRA 1981.

Effective date: Enactment.

(e) *Treatment of Certain County-Operated Health Insuring Organizations.*—Exempts up to three county-operated HMOs that became operational on or after January 1, 1986, and that are designated by the State of California from statutory requirements for Medicaid HMO contracts. The HIOs must be subject to California's own regulatory system for prepaid plans, must enroll all the Medicaid beneficiaries in the county (except qualified Medicare beneficiaries), must assure a reasonable choice of providers, must comply with the requirements for payment adjustments for disproportionate share hospitals, and must pay for children's hospital services for children with special health care needs at rates established by the California Medical Assistance Commission. The exemption applies only if the HIOs enroll no more than 10 percent of all Medicaid beneficiaries in California (not counting qualified Medicare beneficiaries).

House bill

(a) *Requirements for Risk-Sharing Health Maintenance Organizations Under Medicaid.*—

(1) *HMO Minimum Membership Requirements.*—Requires that an HMO or similar organization with a Medicaid risk-sharing contract have a minimum of 5,000 enrollees; permits the Secretary to make payment for an organization with fewer members if it serves primarily members residing in a rural area.

(2) *Application of Minimum Enrollment, Patient Mix, and Financial Solvency Requirements.*—Provides that, if a Medicaid risk-sharing contractor enters into an arrangement under which another entity provides services on a prepaid or other risk basis, the sub-contractor must meet the 75 percent requirement, the 5,000 enrollee requirement added by section (1), and the solvency and reporting requirements. Exceptions from all requirements are provided for federally funded health centers and pre-1970 contractors, and exceptions from the financial and reporting requirements are provided for federally qualified HMOs.

(3) *Prohibition Against Physician Incentive Payments.*—Postpones the effective date for Medicaid only to April 1, 1992.

Effective date: (1) and (2) apply to contract years beginning on or after January 1, 1991. (3) Enactment.

(b) *Special Rules and Medicaid Enrollment Waiver.*—

(1) *Waiver of 75 Percent Rule for Public Entities.*—Deletes the requirement that the Secretary determine that special circumstances warrant a modification before modifying the 75 percent rule for a public entity.

(2) *Extending Special Treatment to Medicare Competitive Medical Plans.*—Extends the lock-in and guaranteed enrollment period options to "competitive medical plans," organizations which are not federally qualified HMOs but which have entered into a risk-sharing contract with the Medicare program. Lock-in for such an organization is permissible if it complies with the 75 percent Medicare/Medicaid enrollment maximum.

(3) *Automatic 1-month Reenrollment for Short Periods of Ineligibility.*—Authorizes automatic HMO reenrollment for individuals

whose period of ineligibility is no longer than 2 months, provided that the organization still has a contract.

(4) *Elimination of Provisional Qualification for HMOs.*—Eliminates provisions relating to provisionally qualified HMOs.

(5) *Medicaid Enrollment Waiver.*—No provision.

Effective date: Enactment.

(c) *Extension and Expansion of Minnesota Prepaid Medicaid Demonstration Project.*—

(1) *Extends the waiver through June 30, 1996.*

(2) *Authorizes the Secretary to treat an undertaking by the Minnesota Medicaid agency in the same way as the New Jersey undertaking.*

Effective date: Enactment.

(d) *Treatment of Dayton Area Health Plan.*—No provision.

(e) *Treatment of Certain County-Operated Health Insuring Organizations.*—No provision.

Effective date: Enactment.

Senate amendment

(a) *Requirements for Risk-Sharing Health Maintenance Organizations Under Medicaid.*—

(1) *HMO Minimum Membership Requirements.*—No provision.

(2) *Application of Minimum Enrollment, Patient Mix, and Financial Solvency Requirements.*—No provision.

(3) *Prohibition Against Physician Incentive Payments.*—(Section 6153 of the Senate amendment repeals the prohibition for both Medicare and Medicaid HMOs and substitutes a system of regulation of physician incentive plans in Medicare HMOs by the Secretary. See section xxxxxxxxxx.) Provides for a civil money penalty of \$25,000 in cases in which an HMO with a Medicaid contract knowingly makes a direct and specific individual payment to a physician as an inducement to withhold or limit a specific medically necessary service to an identifiable patient. Subjects Medicaid HMOs to the new rules established for Medicare HMOs.

Effective date:

(b) *Special Rules and Medicaid Enrollment Waiver.*—

(1) *Waiver of 75 Percent Rule for Public Entities.*—No provision.

(2) *Extending Special Treatment to Medicare Competitive Medical Plans.*—No provision.

(3) *Automatic 1-month Reenrollment for Short Periods of Ineligibility.*—No provision.

(4) *Elimination of Provisional Qualification for HMOs.*—No provision.

(5) *Medicaid Enrollment Waiver.*—Requires the Secretary to approve waivers of the 75 percent Medicare/Medicaid enrollment maximum after: (a) conducting a study of situations in which the limit is impractical or other means of assuring quality and fiscal soundness could be used; (b) publishing by April 1, 1991, for review and comment a set of minimum standards for waiver eligibility; and (c) publishing a final notice of revised standards. Provides that waivers shall initially be approved for 3 years, with renewals as established by the Secretary.

Conference agreement

11. *Miscellaneous Provisions Relating to Health Maintenance Organizations.*—

(a) *Requirements for Risk-Sharing Health Maintenance Organizations Under Medicaid.*—The conference agreement does not include the House bill.

(b) *Special Rules and Medicaid Enrollment Waiver.*—The conference agreement includes the House bill.

(c) *Extension and Expansion of Minnesota Prepaid Medicaid Demonstration Project.*—The conference agreement includes the House bill.

(d) *Treatment of Dayton Area Health Plan.*—The conference agreement does not include the House bill.

(e) *Treatment of Certain County-Operated Health Insuring Organizations.*—The conference agreement includes the House bill.

12. *Miscellaneous Provisions Relating to Demonstration Projects and Home and Community-Based Waivers (Sections 4471-4474 of the House bill; sections 6261-6263, 6270, 6272, and 6276 of the Senate amendment)*

Present law

(a) *Medicaid Long-Term Care Insurance Demonstration Project.*—In most States, Medicaid will cover the cost of long-term care for low-income elderly individuals who are entitled to benefits under the Supplemental Security Income (SSI) program. In order to qualify for SSI, a person must have resources and income below certain levels.

A state may also cover long-term care for elderly individuals with incomes exceeding SSI eligibility levels in several ways. First, a State may establish higher income standards for elderly individuals in nursing facilities. The income levels for these individuals may not exceed 300 percent of the SSI benefit level for an individual. Second, a State may elect to cover under its Medicaid program elderly persons with income below 100 percent of poverty. Third, a State may establish a "medically needy" program under which an individual with income exceeding Medicaid eligibility levels becomes eligible for long-term care by incurring expenses for medical care that reduce his or her income to a level specified by the State. This process is known as "spending down."

Once an individual with income exceeding SSI levels becomes eligible for Medicaid, this person is required to contribute to the cost of care all income in excess of amounts that are disregarded for personal needs and other purposes. This is known as the "post-eligibility treatment of income."

Medicaid law has other provisions requiring States to prohibit the transfer of assets for less than fair market value in order to gain Medicaid coverage for needed care. Medicaid also allows States to place liens on the property of certain Medicaid beneficiaries and permits States to defray the cost of Medicaid assistance paid on behalf of nursing home residents through estate recovery.

(b) *Payment Under Waivers of Freedom of Choice of Hospital Services.*—

(1) *Timely Payment.*—Section 2175 of OBRA 81 permitted a State to obtain a waiver of certain Medicaid requirements, including the beneficiary's right to choose a provider of services, in order to establish a system of selective contracting with providers. Medicaid law includes requirements that States pay health care practitioners, such as physicians, on a timely basis, but makes no such provision for other types of providers, such as hospitals.

(2) *Reasonable and Adequate Payment.*—States must reimburse hospitals at rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities in providing quality care.

(c) *Home and Community-Based Services Waivers.*—

(1) *Clarifying Definition of Room and Board.*—Section 2176 of OBRA 81 permitted States to obtain waivers of certain Medicaid requirements in order to establish a home and community-based service program for a defined population (such as the aged or the mentally retarded) of persons who would otherwise require long-term institutional care. Costs for room and board are excluded from those which a State may include as Medicaid costs under a waiver.

(2) *Treatment of Persons with Mental Retardation or a Related Condition in a Decertified Facility.*—In order to obtain a section 2176 waiver, the State must demonstrate that average per capita Medicaid costs for waiver participants are no greater than would have been incurred in the absence of the waiver.

(3) *Scope of Respite Care.*—One of the services that may be furnished under a home and community-based services waiver is respite care, services that allow family or other voluntary caregivers to take time away from their responsibility for a patient's care.

(4) *Permitting Adjustment in Estimates to Take into Account Preadmission Screening Requirement.*—OBRA 1987 established requirements for screening of mentally retarded or mentally ill patients before admission to a nursing facility, to determine whether alternative treatment is more appropriate. The requirements apply to all persons admitted on or after January 1, 1989.

(5) *Waiver Baseline Under Section 1915(d) Waiver.*—OBRA 1987 established a "section 1915(d)" waiver option, under which a State could provide home and community-based services if it agreed to accept a cap on its total expenditures for long-term care for the elderly, including those served under the waiver and those in nursing homes. The cap is updated annually to reflect increases in the State's elderly population and in a "market basket" index of the prices of long-term care related goods and services. There is no provision for adjustment of the cap to reflect changes in nursing home costs resulting from changes in Medicaid law, such as the nursing home reform provisions of OBRA 1987.

(6) *Freedom of Choice of Case Managers.*—Waivers to provide home and community-based services may not include a waiver of the requirement that beneficiaries must be permitted to obtain covered services from any qualified provider of their choice.

(d) *Provisions Relating to Frail Elderly Demonstration Project Waivers.*—OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or nonprofit private community-based organizations to pro-

vide health care on a capitated basis to the frail elderly at risk of institutionalization. The terms and conditions of the waivers were to be substantially the same as those for On Lok, a project in San Francisco that has provided services to frail elderly at risk of institutionalization.

(e) Demonstration Projects to Study the Effects of Allowing States to Extend Medicaid Coverage to Certain Low-Income Families not Otherwise Qualified to Receive Medicaid Benefits.—No provision.

(f) Demonstration: Respite Care.—Medicaid does not cover respite care services except where provided under a home and community-based services waiver approved by the Secretary under section 1915(c) of Medicaid law. OBRA 86 established a Medicaid respite care demonstration project in the State of New Jersey. This project is intended to determine the extent to which respite services will delay or avert the need for institutional care and how such services can enhance and sustain the role of the family in providing long-term care services for elderly and disabled individuals at risk of institutionalization. The project was to be conducted for a maximum of 4 years (FY 1987 through FY 1990), plus an additional period of up to 6 months for final evaluation and reporting. Federal payments for the project were limited to \$1 million for FY 1987 and \$2 million for each of the following years. The start-up of the project was delayed for a number of reasons.

(g) Demonstration Project to Provide Medicaid Coverage for HIV-Positive Individuals and Certain Pregnant Women Determined to Be at Risk of Contracting the HIV Virus.—No provision.

(h) Mental Health Facility Certification Demonstration Project.—A hospital may be deemed to meet Medicaid and Medicare participation standards if it is accredited by the Joint Commission on Accreditation of Healthcare Facilities (JCAHO). All other types of institutional providers are subject to direct review by State certification agencies.

House bill

(a) Medicaid Long-Term Care Insurance Demonstration Project.—Authorizes the Secretary of HHS to approve State demonstration projects under which persons who are 65 years of age or older and who have exhausted benefits under qualified private long-term care insurance policies to become eligible for Medicaid coverage of their long-term care costs under special eligibility rules pertaining to income and assets as described below.

(1) Special Eligibility Provisions.—Provides that in determining initial eligibility for Medicaid assistance for long-term care that (a) the income of the beneficiary who is 65 years of age or older and who has exhausted benefits under the qualified long-term care insurance policy be disregarded; and (b) the valuation of assets of the beneficiary be reduced by the amount of protection provided under the long-term care insurance policy or \$75,000 (indexed from December 1991 for inflation, as measured by the Consumer Price Index for all urban consumers), whichever is less. For purposes of post-eligibility treatment of income and assets, provides that the amount the beneficiary would be required to contribute toward the cost of long-term care services would be the same as for other persons entitled to Medicaid assistance for these services under the

State plan, except for the assets that can be protected as specified above. Provides that a State Medicaid plan may not discriminate in services covered or otherwise, against any individual based on whether or not the individual participates in a demonstration project.

(2) *Definitions.*—Defines the following terms:

“Covered long-term care beneficiary” means an individual who at any time purchases benefits under a qualified long-term care insurance policy, and who voluntarily elects, at the time of purchase of the policy, to participate in the project.

“Long-term care services” means medical assistance for the following items and services, to the extent the State Medicaid plan otherwise covers such services: (a) nursing facility services; (b) home health services (described in Medicaid law); (c) private duty nursing services; (d) case management services; (e) homemaker/home health aide services; (f) personal care services; (g) adult day health services; (h) respite care.

“State Medicaid plan” means the plan of medical assistance of a State approved under title XIX of the Social Security Act.

“Qualified long-term care insurance policy” means a long-term care insurance policy that meets the requirements specified below.

(3) *Terms of Projects.*—Establishes terms of the projects:

(A) *General.*—Prohibits the Secretary from approving any project unless it meets the following requirements: (1) The terms of the project are disclosed to each individual before the individual is enrolled; and (2) the qualified long-term care insurance made available in connection with the project cannot, or otherwise limit, payment under the policy in any manner because the insured is eligible for, or payment may be made, for services under any public program (including the Medicare or Medicaid programs).

(B) *Limit on Number of Lives Insured under All Projects.*—Requires that the Secretary approve projects in a manner that assures that there are never more than 25,000 covered long-term care beneficiaries under all the projects. Provides that the Secretary may require that a project of a State must permit enrollment of a minimum number of covered long-term care beneficiaries.

(C) *Waiver of Certain Requirements.*—Provides that the Secretary may waive the following requirements for covered long-term care beneficiaries to the extent required to carry out the project: sections 1901, 1902(a)(1), 1902(a)(10), 1902(a)(17), and 1903(f), relating to required eligibility and benefits; and sections 1902(a)(14) and 1916(b), relating to premiums and cost-sharing.

(4) *Limitation on Payments.*—Provides that Federal matching payments may not be made for long-term care services for persons 65 years of age or older during a year in which the project is in effect to the extent that expenditures exceed the projected amount (determined by the Secretary at the time of approval of the project) that the State would have spent for these services during the year, if the project had not been in effect.

(5) *State Assurances.*—Prohibits the Secretary from approving State applications for a project unless the State provides satisfactory assurance that—

(a) aggregate expenditures under the plan for long-term care services for individuals 65 years of age or older in any fiscal year

under the project will not exceed the aggregate expenditures for such services for these individuals in the fiscal year in the absence of the project;

(b) there will be no reduction or limitation of benefits to any individual eligible for medical assistance under the State Medicaid plan as a result of operation of the project;

(c) the State will continue to make long-term care services available under its Medicaid plan, at least to the extent these services are made available under its plan before the date of approval and could continue to be provided consistent with law;

(d) the State will not permit the sale of any qualified long-term care insurance policy under the project unless the State has determined that the policy meets requirements specified below and meets standards at least as stringent as those set forth in the NAIC Long-Term Care Insurance Model Act, as of June 1989 (to the extent not inconsistent with the requirements specified below);

(e) in the sale of long-term care insurance policies not covered under the project, the State will require, at or before the time of sale of a policy, that there be a disclosure of the fact that purchase of the policy will not provide potential benefits under Medicaid;

(f) the State will guarantee the payment of benefits under qualified long-term care insurance policies sold under the project (Federal matching payments would not be available with respect to a State's performance of the guarantee);

(g) the State covers under its Medicaid plan pregnant women and children under the age of one with income up to 185 percent of poverty;

(h) the State is in compliance with various requirements for nursing facilities participating in Medicaid;

(i) nursing facilities participating in Medicaid establish and maintain identical policies and practices regarding admission for all individuals regardless of whether or not the individuals are participating in the project;

(j) the State has actuarial guidelines regarding, and actuaries capable of evaluating, actuarial submissions of companies seeking to offer qualified long-term care insurance policies under the project; and

(k) the State has provided for a program of counseling residents of the State on the purchase of long-term care insurance policies and alternative financial option for protection of assets.

(6) Requirements for Qualified Long-Term Care Insurance Policies.—Provides that qualified long-term care insurance policies meet the following requirements:

(a) Standard Format and Disclosure.—Each policy, and application for policy, must be written in simple, easily understood English in a standard format (established by the State) providing standardized terms and disclosure. Marketing materials must be written or otherwise state in simple, easily understood English. No policy may be sold (or offered for sale) unless there is disclosed in writing, no later than the time of sale of the policy, (1) the proportion of premiums collected (and interest and other revenues derived therefrom) which will be applied to payment of benefits, and (2) the potential Medicaid benefits associated with the demonstration project with purchase of a policy.

(b) *Minimum Loss-Ratio.*—The policy must guarantee over time, using generally accepted actuarial standards, that at least 70 percent of the amount of the premiums (and interest and other revenues derived therefrom) will be paid on benefits under the policy.

(c) *Standard Minimum Benefits.*—Each policy must cover at least nursing facility services and home and community-based care (personal care services including home health aide and homemaker services, home health services, and respite) up to the maximum dollar level of benefits provided under the plan. The policy may not impose any limits on the duration of the period of services under the policy, other than the maximum dollar level of benefits (which shall apply uniformly to all services). The payment levels established for services under the plan must be adjusted at least annually to reflect the percentage increase in the Consumer Price Index for All Urban Consumers.

(d) *Specification of Maximum Dollar Level of Benefits.*—Each policy must specify a maximum dollar level of benefits. This maximum must be increased, in each year after the year following the year of its issuance, by the percentage increase in the Consumer Price Index for All Urban Consumers.

(e) *Determination of Benefit Eligibility.*—Each policy must use a standard formula, set by the State and based on a uniform assessment instrument specified by the State, to determine the level of care appropriate for each case. The formula must be applied by the State or a case-management agency which is independent of the issuer of the policy. A policy may not condition or limit eligibility for noninstitutional benefits to the need for or receipt of institutional services; for home care services to the need for or receipt of nursing care; or for any benefits on the medical necessity for such benefits. Each policy must provide for and specify procedures (meeting reasonable standards specified by the State) for the appeal of determinations of level of care.

(f) *Limitation Based on Pre-Existing Condition.*—A policy may not limit or delay an individual's eligibility for benefits based on a pre-existing condition, except that it may deny payments during the first 6 months of coverage for treatment for any condition that existed during the 6 months before the date of the purchase of the policy.

(g) *No Post-Claims Conditioning and Guaranteed Renewable.*—After a policy has been issued, the issuer may not deny claims under the policy under any grounds other than fraud or a knowing misrepresentation in the application for the policy or deny renewal of coverage other than on such grounds or the failure to make timely payment of premiums.

(h) *Medical Underwriting, Premiums, and Cost-Sharing.*—

(1) *No Medical Underwriting.*—An individual may not be discriminated against in the offering, renewal, or benefits under a policy based on the individual's medical condition, except that the issuer of a policy may deny initial issuance to an individual receiving long-term care services at the time of the application for a policy. The prohibition on medical underwriting would not prevent the issuer of a policy from varying the premiums based on the age classification of persons at the time of the issuance of the policy.

(2) *Level Premiums.*—Each policy must have periodic premiums that are the same for all individuals in the same age group who purchased the policy when they were in the same age group. The premium rates must be guaranteed for the duration of the policy and must be suspended during any period in which benefits are payable under the policy.

(3) *Nonduplication of Medicare Benefits.*—Each policy must provide that, to the extent required under Medicare secondary payer provisions, benefits are not payable under the policy for services for which payment may be made under Medicare.

(4) *Reduced Paid-Up Provision.*—Each policy must have a provision under which, if the policy lapses after 5 or more years of coverage, the policy will provide, without payment of any additional premiums, benefits equal to at least 30 percent of the maximum dollar level of benefits available at term, and, after subsequent periods of coverage, the policy will provide, without payment of any additional premium, benefits equal to at least an increased percentage established by the Secretary) of the maximum dollar level of benefits available at term.

(5) *Additional Consumer Protections.*—Each policy must meet such standards relating to compensation arrangements, advertising, marketing, and appropriateness of purchase which the Secretary finds are equal to or more stringent than the requirements specified in sections 12, 15, 16, and 17 of Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Act, as adopted by the National Association of Insurance Commissioners as of December 7, 1989.

(i) *Access to Information.*—The issuer of the policy will make available to the State and the Secretary (upon request) information on the utilization of benefits and payments under the policy, the health status of individuals purchasing the policies, and such other information as the Secretary may require, including information on lapse rates, rescissions, application denials, payment denials, and complaints received.

(7) *Prohibited Sales Practices.*—Provides that each individual selling or offering for sale a long-term care insurance policy under the demonstration project has a duty of good faith and fair dealing to the purchaser or potential purchaser of a policy. Specifies that the individual selling or offering for sale a policy may not complete the medical history portion of an application; may not knowingly sell a policy to provide benefits to a person who is eligible for Medicaid; and may not sell a policy knowing that the policy provides coverage that duplicates coverage already provided and may not sell a policy unless the individual (or representative of the individual) provides a written statement to the effect that the coverage does not duplicate other coverage in effect. Provides that any person who sells a policy under the demonstration in violation of State requirements for qualified policies or who violates the above requirements will be subject to a civil money penalty of not to exceed \$25,000 for each violation. Specifies that the provisions of sections 1128A of the Social Security Act (civil money penalties) will apply, with certain exceptions, to these penalties.

(8) *Application, Duration, and Eligibility.*—Provides that an application for approval of a demonstration project will be deemed

granted unless the Secretary, within 90 days after the date of its submission, either denies the application in writing or informs the State in writing of any additional information which is needed in order to make a final determination on the application. Specifies that after the date the Secretary receives the additional information, the application will be deemed granted unless the Secretary, within 90 days, denies the application. Provides that any termination of a project shall not affect covered long-term care beneficiaries who purchased qualified long-term care insurance policies before the termination date.

(9) *Annual State Reports.*—Requires the States to report annually (during the project) to the Secretary on—

(a) the number of individuals enrolled in the demonstration project in the State;

(b) the number of enrollees actually receiving long-term care services under the demonstration (whether through long-term care insurance or Medicaid);

(c) the number of enrollees actually receiving long-term care in the form of medical assistance;

(d) the average income, age, and assets of each enrollee; and

(e) the number and characteristics of private insurers with policies approved by the State under the demonstration.

(10) *Secretary's Reports.*—Requires the Secretary to submit to Congress reports on the demonstration projects. Requires that the first report be submitted in 1997 and subsequent reports be submitted each 6th year thereafter until 2021. Requires that each report summarize and analyze information reported by the State (as specified above) and that it evaluate the cost effectiveness of the projects.

Effective date: Enactment.

(b) *Payment Under Waivers of Freedom of Choice of Hospital Services.*—

(1) *Timely Payment.*—Extends prompt payment requirements to any type of provider participating under a selective contracting waiver.

(2) *Reasonable and Adequate Payment.*—No provision.

Effective date: (1) is effective as of the first calendar quarter beginning more than 30 days after enactment.

(c) *Home and Community-Based Services Waivers.*—

(1) *Clarifying Definition of Room and Board.*—Provides that the "room and board" exclusion does not apply to the share of rent and food costs attributable to an unrelated caregiver who is residing with a waiver participant and without whom the participant would require institutional care.

(2) *Treatment of Persons with Mental Retardation or a Related Condition in a Decertified Facility.*—Provides that, in estimating per capita costs in the absence of a waiver for persons with mental retardation or a related condition who are residents of an ICF-MR whose Medicaid participation has been terminated, the State may use the costs that would have been incurred if the facility had not been terminated.

(3) *Scope of Respite Care.*—Provides that, so long as a State meets the cost-effectiveness test for a waiver, the Secretary may not limit the hours or days of respite care that may be provided.

(4) *Permitting Adjustment in Estimates to Take into Account Preadmission Screening Requirement.*—Provides that, in the case of a waiver program for the mentally retarded, a State may revise its per capita cost estimates to take into account increases in ICF-MR or habilitation facility costs resulting from implementation of the pre-admission screening requirement.

(5) *Waiver Baseline Under Section 1915(d) Waiver.*—No provision.

(6) *Freedom of Choice of Case Managers.*—No provision.

Effective date: (1) applies to services furnished on or after the date of enactment. (2) applies as if included in the enactment of OBRA 1981, but applies only to facilities whose Medicaid participation is terminated after enactment. (3) applies as if included in the enactment of OBRA 1981. (4) Enactment.

(d) *Provisions Relating to Frail Elderly Demonstration Project Waivers.*—Expands the number of frail elderly demonstrations eligible for waivers from 10 to 15 and prohibits the Secretary from requiring an organization receiving an initial waiver on or after October 1, 1990, to provide services under Medicare on a capitated or other risk basis during the first 2 years of the waiver. Also applies spousal impoverishment protections to persons receiving services under the frail elderly demonstration.

Effective date: Enactment.

(e) *Demonstration Projects to Study the Effects of Allowing States to Extend Medicaid Coverage to Certain Low-Income Families not Otherwise Qualified to Receive Medicaid Benefits.*—No provision.

(f) *Demonstration: Respite Care.*—No provision.

(g) *Demonstration Project to Provide Medicaid Coverage for HIV-Positive Individuals and Certain Pregnant Women Determined to Be at Risk of Contracting the HIV Virus.*—No provision.

(h) *Mental Health Facility Certification Demonstration Project.*—No provision.

Senate amendment

(a) *Medicaid Long-Term Care Insurance Demonstration Project.*—Requires the Secretary of HHS to provide for a demonstration project in the States of Indiana, Illinois, Wisconsin, Oregon, California, Connecticut, Massachusetts, Missouri, New York, and New Jersey to cover under Medicaid the long-term care expenses of persons with income and resources above Medicaid eligibility levels, if the individual purchases a State approved long-term care insurance policy covering long-term care for a period preceding the individual's eligibility for Medicaid.

(1) *Special Eligibility Provisions.*—No provision.

(2) *Definitions.*—No provision.

(3) *Terms of Projects.*—

(A) *General.*—No provision.

(B) *Limit on Number of Lives Insured under All Projects.*—No provision.

(C) *Waiver of Certain Requirements.*—Provides that the Secretary may waive the following requirements for the project: sections 1901, 1902(a)(10) (A) and (C), 1903(a)(1), and 1903(f), relating to categorical and income eligibility limits; sections 1902(a)(10) (A) and (D), relating to amount, duration, and scope of services; and to diagnosis, type of illness, or condition; section 1902(a)(10)(E), relating to

qualified Medicaid beneficiaries; section 1902(a)(23), relating to freedom of choice; section 1902(a)(1), relating to statewideness; sections 1902(a)(10), matter following (E) and 1902(a)(17), relating to comparability; section 1902(a)(14), relating to premiums; section 1902(a)(18), relating to liens and recovery of assets; sections 1902 (50) and (51), relating to personal needs allowance, protection of community spouse, and transfer of assets.

(4) *Limitation on Payments.*—No provision.

(5) *State Assurances.*—Requires that States conducting demonstration projects provide assurances to the Secretary that—

(a) the estimated average per capita and aggregate expenditures for long-term care services for individuals under the waiver will not exceed estimated average per capita and aggregate Medicaid expenditures for such services for these individuals in the absence of the waiver;

(b) it will continue to make long-term care services available under its Medicaid plan to any individual who would be entitled to long-term care services before the waiver (except to the extent that subsequent Federal legislation specifically requires changes in eligibility for these services);

(c) it will not approve a long-term care insurance policy unless it meets standards at least as stringent as those set forth in the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act as of June 1989; and

(d) expenditures for long-term care services provided to individuals participating in the projects after the expiration of the projects shall be shared by State and Federal Governments in accordance with Medicaid formulae in force at the time.

(6) *Requirements for Qualified Long-Term Care Insurance Policies.*—No provision.

(7) *Prohibited Sales Practices.*—No provision.

(8) *Application, Duration, and Eligibility.*—Requires the Secretary to enter into an agreement with the States for conducting the demonstration projects and to award the demonstrations in a budget neutral way. Requires the Secretary to either approve or disapprove the State's application within 90 days of receipt. If the Secretary disapproves an application, requires the Secretary within 30 days of disapproval to notify the State of the reasons for the disapproval and to allow the State to correct any deficiencies and allow the State to resubmit a corrected application which the Secretary must approve if it meets the requirements for the demonstration. Specifies that the demonstration would be for an initial period of 5 years and provides for renewal for an additional 5 years. Provides that an individual who participates in a demonstration will remain eligible for long-term care services under the State Medicaid plan after the expiration of the project.

(9) *Annual State Reports.*—Similar provisions for items (a) through (c), with a fourth item: the number and type (commercial, not for profit, and HMO) characteristics of private insurers with policies approved by the States under the demonstrations.

(10) *Secretary's Reports.*—Requires the Secretary to report to Congress on the demonstration not later than 4 years after the date of enactment. Requires that the report summarize and analyze infor-

mation reported by the State (as specified above) and that it evaluate the cost effectiveness of the project and make recommendations on the desirability and appropriateness of authorizing any State to make long-term care services available on a similar basis.

Effective date: Enactment.

(b) Payment Under Waivers of Freedom of Choice of Hospital Services.—

*(1) Timely Payment.—*No provision.

*(2) Reasonable and Adequate Payment.—*Prohibits the Secretary from waiving the statutory requirement relating to adequacy of hospital reimbursement rates as part of a section 2175 selective contracting waiver.

Effective date: (2) is effective for calendar quarters beginning on or after January 1, 1991.

(c) Home and Community-Based Services Waivers.—

*(1) Clarifying Definition of Room and Board.—*Similar provision.

*(2) Treatment of Persons With Mental Retardation or a Related Condition in a Decertified Facility.—*Similar provision.

*(3) Scope of Respite Care.—*No provision.

*(4) Permitting Adjustment in Estimates To Take into Account Preadmission Screening Requirement.—*No provision.

*(5) Waiver Baseline Under Section 1915(d) Waiver.—*Requires that the base for the expenditure cap under a section 1915(d) waiver be adjusted to reflect changes in cost resulting from legislation.

*(6) Freedom of Choice of Case Managers.—*Allows the State to restrict the choice of providers of case management services under a waiver program to those employed or trained by the State, provided that the State furnishes assurances to the Secretary that the restriction will not substantially limit beneficiaries' access to waiver services.

Effective date: Enactment.

*(d) Provisions Relating to Frail Elderly Demonstration Project Waivers.—*No provision.

Effective date: No provision.

*(e) Demonstration Projects To Study the Effects of Allowing States To Extend Medicaid Coverage to Certain Low-Income Families Not Otherwise Qualified to Receive Medicaid Benefits.—*Requires the Secretary to enter into agreements with at least 3 and no more than 4 States to conduct demonstrations to study the effect on access to and costs of health care for uninsured individuals in families with incomes below 150 percent of the official poverty line. At least 1, but not more than 2, of the projects shall be conducted on a sub-State basis in an area that contains a high percentage of racial or ethnic minorities. The Secretary may not enter into an agreement with a State unless that State has elected to offer Medicaid coverage to all pregnant women, infants, and children at the highest income standards without application of a resource standard; this requirement, and some other Medicaid requirements, may be waived for projects conducted in sub-State areas. If the Secretary determines it is cost-effective to do so, a project may use employer coverage, requiring an employer contribution and using Medicaid benefits to the extent they are not available under the employer coverage. Permits application of an asset test consistent with the State's tests for AFDC. Does not provide

for eligibility to begin before the month in which eligibility is established.

Except in the sub-State projects, prohibits projects from providing nursing facility, community-based long-term care, or pregnancy-related services. Permits a State to limit eligibility, or services other than early and periodic screening, diagnosis and treatment for children under age 18.

No premiums or cost-sharing may be required of individuals with family incomes below the poverty line. For those with incomes above 100 percent of the poverty line, the monthly average amount of premiums, coinsurance, and other cost-sharing must not exceed 3 percent of the family's average gross monthly earnings. Income determinations must be according to the methodology used under Medicaid for AFDC beneficiaries.

Provides that demonstrations are to begin by July 1, 1991, and continue for 3 years unless the Secretary finds the State noncompliant with program requirements. Limits expenditures for the projects to \$12,000,000 in each of fiscal years 1991-1993, and to \$4,000,000 in fiscal year 1994. Requires the Secretary to submit an interim report to Congress by January 1, 1993, and a final report by January 1, 1995.

Effective date: Enactment.

(f) *Demonstration: Respite Care.*—Extends the demonstration until September 30, 1992, and requires that for the period October 1, 1990 through September 30, 1992, Federal payments for the project not exceed amounts expended under the project in the preceding fiscal year.

Effective date: Enactment.

(g) *Demonstration Project To Provide Medicaid Coverage for HIV-Positive Individuals and Certain Pregnant Women Determined To Be at Risk of Contracting the HIV Virus.*—Requires the Secretary, within 3 months after enactment, to provide for 2 State Medicaid demonstration projects providing Medicaid coverage and specified additional services to: (a) persons testing positive for infection with the human immunodeficiency virus (HIV) who meet the State's maximum income and resource standards for disabled persons, or (b) pregnant women under age 19 who have multiple medical and psychosocial needs and who are determined to be at risk of HIV infection because of substance abuse. Services to be furnished include (to the extent not otherwise covered under the State plan) general and preventive medical care, prescription drugs, counseling and social services, substance abuse treatment, home care, case management, health education, respite care, and dental services. Requires demonstration States to enter into agreements with hospitals within 12 months under which the hospitals will be paid on a monthly per capita basis for services to project enrollees. Limits enrollment in each project to 200 persons. Provides that projects are to begin within 9 months after enactment and continue for 3 years. Provides for Federal matching at the applicable Federal medical assistance percentage, and authorizes the Secretary to waive requirements of the Social Security Act as necessary to carry out the projects.

Effective date: Enactment.

(h) Mental Health Facility Certification Demonstration Project.—Requires the Secretary to conduct a 5-State, 3-year demonstration program under which outpatient mental health and substance abuse facilities or residential or day treatment services for children may be deemed to meet Medicaid standards on the basis of approval by accrediting bodies. The demonstration is to be developed in consultation with JCAHO and other national accrediting bodies, the National Governors' Association and other associations of State officials, consumer organizations, and other parties. The Secretary must develop criteria for accrediting bodies' activities, assuring that inspections are unannounced, the public and the State have access to findings of inspections, deficiencies are documented and promptly reported to the State, complaints by recipients of service or advocates are investigated, and the State conducts periodic validation inspections to assess the accrediting bodies' work. Criteria, which must also address standards, reporting requirements, and duration of accreditation, are to be published in the Federal Register within 9 months after enactment; the Secretary must allow 90 days for public comment. Within 180 days after termination of the project, the Secretary is required to submit an evaluation to the Senate Committee on Finance, including the extent of accrediting bodies' participation, provider compliance, impact on access and quality, and ability of accrediting bodies and States to work together to resolve problems and complaints, along with such recommendations as the Secretary deems appropriate.

Effective date: Enactment.

Conference agreement

12. Miscellaneous Provisions Relating to Demonstration Projects and Home and Community-Based Waivers.—

(a) Medicaid Long-Term Care Insurance Demonstration Project.—The conference agreement does not include the provision.

(b) Payment Under Waivers of Freedom of Choice of Hospital Services.—The conference agreement includes item (1) of the House bill.

(c) Home and Community-Based Services Waivers.—The conference agreement includes items (2), (3), and (4) of the House bill and items (1), (5), and (6) of the Senate amendment, with an amendment to item (6).

(d) Provision Relating to Frail Elderly Demonstration Project Waivers.—The conference agreement includes the House bill with an amendment which clarifies that, for these projects, application of spousal impoverishment protections is at the option of the State.

(e) Demonstration Projects To Study the Effects of Allowing States To Extend Medicaid Coverage to Certain Low-Income Families not Otherwise Qualified To Receive Medicaid Benefits.—The conference includes the Senate amendment with amendments to (1) delete references to racial/ethnic targetting, and (2) clarify the provision is applicable only to uninsured individuals who are not otherwise eligible to receive Medicaid benefits.

(f) Demonstration: Respite Care.—The conference agreement includes the Senate amendment.

(g) Demonstration Project To Provide Medicaid Coverage for HIV-Positive Individuals and Certain Pregnant Women Determined to be

at Risk of Contracting the HIV Virus.—The conference agreement includes the Senate amendment, with amendments to the specifications for patients, services, and grantees under the projects, and for the scope of the demonstrations projects. The agreement limits expenditures for the projects to \$30 million.

(h) Mental Health Facility Certification Demonstration Project.—The conference agreement includes the Senate amendment, with an amendment.

13. Other Miscellaneous Provisions (Sections 4481 through 4485 of the House bill)

Present law

(a) Medicaid State Plans Assuring the Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient.—

(1) In General.—No provision.

(2) Study to Assess Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient.—No provision.

(3) Public Education Demonstration Project.—No provision.

(b) Improvement in Quality of Physician Services.—

(1) Use of Unique Physician Identifiers.—COBRA required the Secretary to establish a system of unique identifiers for physicians providing services under Medicare. No such provision applies to physicians providing services under Medicaid. However, each Medicaid program must have a mechanized claims processing and information retrieval system approved by the Secretary (the requirement may be waived for commonwealths and territories and for certain States with a small population and low Medicaid expenditures in 1976.) One of the Secretary's criteria for approval of State systems is the use of unique identifiers for physicians and the inclusion of such identifiers on all paid claims.

(2) Foreign Medical Graduate Certification.—States must generally allow any licensed physician to participate in Medicaid.

(3) Minimum Qualifications for Billing for Physicians' Services to Children and Pregnant Women.—No provision.

(4) Reporting of Misconduct or Substandard Care.—The Health Care Quality Improvement Act of 1986 (P.L. 99-660) required the Secretary to establish a central clearinghouse for certain information on providers, including sanctions taken against them and malpractice actions. A State participating in Medicaid must have a system for reporting by State or local licensing authorities of cases in which a provider's license is revoked or suspended (or surrendered while a formal proceeding is pending) or other disciplinary action is taken.

(c) Clarification of Authority of Inspector General.—The Secretary has the authority to exclude individuals and entities from Medicare and Medicaid participation and to impose civil monetary penalties for specified infractions.

(d) Notice to State Medical Board When Adverse Actions Taken.—A State Medicaid agency must promptly notify the Secretary of HHS when a provider or other person is terminated, suspended, or otherwise sanctioned or prohibited from participating in Medicaid.

(e) Miscellaneous Provisions.—

(1) Psychiatric Hospitals.—

(A) States may cover inpatient psychiatric hospital services as an optional Medicaid benefit for beneficiaries under age 21. The Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369) provided that a State may cover such services only if the facility (or part of a facility) meets the Medicare definition of a psychiatric hospital.

(B) Current law provides for intermediate sanctions to be imposed on nursing facilities and intermediate care facilities for the mentally retarded (ICFs-MR), but has no such provisions for inpatient psychiatric hospitals.

*(2) State Utilization Review Systems.—*OBRA 86 prohibited the Secretary from promulgating regulations requiring States to establish mandatory second surgical opinion programs or inpatient hospital preadmission review until 180 days after the Secretary submitted to the Congress a report on the extent to which such programs impede access to care and a variety of related issues concerning Medicaid beneficiaries' access to high volume or high cost procedures. The report was submitted in June 1989. The Administration's FY 1990 budget proposal indicated that the Administration plans to proceed with requirements that States implement second opinion and preadmission review programs, and also plans to require that States implement two additional utilization control approaches. The first would require substitution of ambulatory and same-day surgery for inpatient surgery. The second would require that medical tests ordinarily performed at the start of an inpatient hospital admission be performed on an outpatient basis before the admission.

(3) Additional Miscellaneous Provisions.—

(A) If a State covers under Medicaid services in institutions for medical diseases and/or intermediate care facilities for the mentally retarded, it must also cover a specified minimum set of basic health services.

(B) The Federal Food, Drug, and Cosmetic Act prohibits the unauthorized disclosure of a method or process entitled to protection as a trade secret, except to DHHS or to the courts.

(C) No provision.

House bill

(a) Medicaid State Plans Assuring the Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient.—

*(1) In General.—*Provides that States must require hospitals, nursing facilities, home health or personal care providers, hospices, and HMOs receiving Medicaid funds to comply with requirements relating to patient advance directives, including living wills and other instructions recognized under State law relating to care when an individual is incapacitated. Requires that providers have written policies and procedures to (a) inform all adult patients at the time treatment is initiated (or on enrollment, in the case of an HMO) of their right to execute an advance directive and of the hospital's policies on implementation of that right, (b) document in medical records whether or not an individual has executed an advance directive, (c) not condition treatment or otherwise discrimi-

nate on the basis of whether a patient has executed an advance directive, (d) comply with State laws on advance directives, and (e) provide education for staff and the community on advance directives.

(2) *Study to Assess Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient.*—Requires the Secretary to enter into an agreement with the Institute of Medicine (IOM) to conduct a study of the context in which decisions on advance directives are made and carried out, including the incidence of process of decisions on life-sustaining treatments made with and without directives. Requires the Secretary to contract with IOM within 28 days after receiving an acceptable application. If IOM does not submit an acceptable application, requires the Secretary to select another contractor. Requires that the contractor report on the study to the Secretary and the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance within 4 years after enactment, including recommendations for such legislation as may be appropriate to carry out the purposes of this section.

(3) *Public Education Demonstration Project.*—Requires the Secretary, within 6 months after enactment, to develop and implement in selected States a demonstration project to inform the public of the option to execute advance directives and the patient's right to participate in and direct health care decisions. Requires the Secretary to report to the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance on the results of the project and whether it should be extended.

Effective date: (1) Applies to services furnished on or after the first day of the first month beginning more than 1 year after enactment. (2) and (3) Enactment.

(b) *Improvement in Quality of Physician Services.*—

(1) *Use of Unique Physician Identifiers.*—Requires the Secretary to establish a system, for implementation by July 1, 1991, for unique identifiers for physicians providing services for which payment may be made under Medicaid; the system may be the same as or different from the system for Medicare. Provides that, beginning with services furnished on or after the first day of the first quarter beginning more than 60 days after establishment of the system, Federal funding will be available for Medicaid physician services only when the unique identifier appears on the claim for the services. Requires that Medicaid contracts with HMOs require that the HMO maintain data on patient encounters sufficient to identify the physician who treated the patients. Requires that the State maintain a list, updated monthly, of the identifiers of physicians certified to participate under Medicaid.

(2) *Foreign Medical Graduate Certification.*—Provides that no unique identifier may be issued (and hence no Medicaid payment may be made to) a foreign medical graduate who has not passed the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) or previously received certification from or passed the examination of, the Educational Commission for Foreign Medical Graduates.

(3) *Minimum Qualifications for Billing for Physicians' Services to Children and Pregnant Women.*—Prohibits Medicaid payment for

physician services to pregnant women or children under 21 furnished on or after January 1, 1992, unless the physician is board-certified in family practice or pediatrics or obstetrics (as appropriate), is employed by or affiliated with a federally qualified health center, has admitting privileges at a Medicaid-participating hospital, is a member of the National Health Service Corps, or has a documented consulting relationship with a family practitioner, pediatrician, or obstetrician for purposes of specialized treatment and hospital admission.

(4) Reporting of Misconduct or Substandard Care.—Requires that a State's system also provide for reporting by peer review organizations and private accreditation entities, and include reporting of any negative action taken by such organizations or entities or by licensing agencies.

Effective date: (1) Enactment, except that HMO recordkeeping requirements are effective for contract years beginning after the date of the establishment of the system of unique physician identifiers; the requirement that States maintain updated lists of identifiers applies to Medicaid payments for quarters beginning more than 60 days after establishment of the system. (2) applies with respect to the issuance of an identifier applicable to services furnished on or after January 1, 1992. (3) Enactment. (4) applies to State information systems as of January 1, 1992, regardless of whether implementing regulations have been promulgated.

(c) Clarification of Authority of Inspector General.—Clarifies that the Secretary may delegate this authority to the Inspector General of the Department of Health and Human Services.

Effective date: Enactment.

(d) Notice to State Medical Board When Adverse Actions Taken.—Provides that the Medicaid agency must also notify the State medical licensing board when the adverse action is taken against a physician, regardless of ordinary requirements relating to patient confidentiality.

Effective date: Applies to sanctions effected more than 60 days after enactment.

(e) Miscellaneous Provisions.—

(1) Psychiatric Hospitals.—

(A) Allows the Secretary to specify in regulations alternative settings in which inpatient psychiatric services may be covered

(B) Establishes sanction provisions for inpatient psychiatric hospitals, as follows:

(i) If a State finds that a psychiatric hospital fails to meet certification requirements then, if the deficiencies immediately jeopardize the health and safety of patients, the State must terminate hospital's Medicaid participation. If there is no such immediate jeopardy, the State may choose to terminate participation, deny payment for individuals admitted after the date of the finding, or both.

(ii) If non-compliance continues for 3 months, the State must deny payment for new admissions; if it continues for 6 months, Federal funding for services in the hospital is denied until the hospital achieves compliance. Federal funding may be continued during the 6-month period if the State has an approved plan for corrective action, provided the State agrees to repay the funds if the plan is not complied with.

(2) *State Utilization Review Systems*.—Makes permanent that prohibition against requiring States to establish mandatory second surgical opinion or preadmission screening programs. Prohibits the Secretary from promulgating regulations requiring States to establish programs for ambulatory or same-day surgery or preadmission testing until 180 days after the Secretary has reported to Congress, for a representative sample of States, an analysis of procedures for which ambulatory or same-day surgery or preadmission testing are appropriate for Medicaid patients, and the effects of such programs on access, quality, and costs. Requires that the sample include some States that include such programs. Requires the Secretary to submit the report by January 1, 1993.

(3) *Additional Miscellaneous Provisions*.—

(A) Adds the services of pediatric or family nurse practitioners to the list of minimum required services, effective July 1, 1990.

(B) Provides, effective as if included in OBRA 1989, that the prohibition does not authorize withholding of information from Congress or congressional committees.

(C) Makes a technical change in the law relating to the Maternal and Child Health Block Grant.

Effective date: Enactment.

Senate amendment

(a) *Medicaid State Plans Assuring the Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient*.—

(1) *In General*.—

(2) *Study to Assess Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient*.—

(3) *Public Education Demonstration Project*.—

Effective date:

(b) *Improvement in Quality of Physician Services*.—No provision.

(c) *Clarification of Authority of Inspector General*.—No provision.

(d) *Notice to State Medical Board When Adverse Actions Taken*.—No provision.

(e) *Miscellaneous Provisions*.—

(1) *Psychiatric Hospitals*.—No provision.

(2) *State Utilization Review Systems*.—No provision.

(3) *Additional Miscellaneous Provisions*.—No provision.

Conference agreement

13. *Other Miscellaneous Provisions*.—

(a) *Medicaid State Plans Assuring the Implementation of a Patient's Right to Participate in and Direct Health Care Decisions Affecting the Patient*.—The conference agreement includes the House bill, with amendments that exclude a study by the Institute of Medicine, and provide that the public education projects shall be national in scope, rather than a demonstration project.

(b) *Improvement in Quality of Physician Services*.—The conference agreement includes the House bill with amendments.

(c) *Clarification of Authority of Inspector General*.—The conference agreement includes the House bill.

(d) *Notice to State Medical Board When Adverse Actions Taken*.—The conference agreement includes the House bill.

(e) *Miscellaneous Provisions.*—The conference agreement includes items (1), (2), and (3) of the House bill.

TITLE V—INCOME SECURITY, HUMAN RESOURCES, AND RELATED PROGRAMS

I. SUBTITLE A—HUMAN RESOURCE AND FAMILY POLICY AMENDMENTS

A. Chapter I—Child Support Enforcement

1. EXTENSION OF IRS INTERCEPT FOR NON-AFDC FAMILIES

(Section 5011 of the Conference Agreement)

Present law

States may collect child support arrearages of at least \$500 owed to non-AFDC families through the Federal income tax refund offset mechanism. This provision expires at the end of 1990. A similar mechanism is authorized permanently for AFDC families, but the limit on arrearages is set at \$150 by regulations. The arrearages must be owed to a "minor child." Spousal support is excluded from the definition of support that can be collected through this offset.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6001 of Senate amendment)

The provision permanently extends the present law provision that allows States to ask the IRS to collect child support arrearages of at least \$500 out of income tax refunds otherwise due to non-custodial parents. The minor child restriction would be eliminated for adults with a current support order who are disabled, as defined under OASDI or SSI. In addition, the offset could be used for spousal support when spousal and child support are included in the same support order.

The provision would take effect on January 1, 1991.

Conference agreement

The conference agreement follows the Senate amendment.

2. EXTENSION OF INTERSTATE CHILD SUPPORT COMMISSION

(Section 5012 of the Conference Agreement)

Present law

The Family Support Act of 1988 established the Interstate Child Support Commission to report to Congress no later than May 1, 1991 on recommendations for improvements in the child support enforcement system and the Uniform Reciprocal Enforcement of Support Act. The Commission expires on July 1, 1991.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6002 of Senate amendment)

The provision would extend the life of the Commission to July 1, 1992 and would require it to submit its report no later than May 1, 1992. Also, the provision would authorize the Commission to hire its own staff.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

3. CHILD SUPPORT DEMONSTRATION**(Section 5013 of the Conference Agreement)***Present law*

The Federal Government matches approved child support expenditures by States at a rate of 66 percent of total costs. The law requires each State to obtain an application for services from each family before this Federal matching can be received. By regulation, HHS has interpreted this requirement to mean a written application. The Secretary has disallowed Federal matching in some States if a written application has not been obtained.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes an amendment that would grant the State of Texas a waiver to continue an ongoing project in Bexar County on delinquency monitoring for child support enforcement. The State agency would be allowed to accept clients for the enforcement of court-established child support obligations without a written application and without collection of an application fee. The following conditions for granting this waiver would be established:

(1) The State agency must permit custodial parents to decline receiving child support services in writing before any services are provided;

(2) The State agency must ensure that the custodial and non-custodial parents are informed fully in writing about their rights and about the services and responsibilities of the agency during delinquency monitoring;

(3) The time frame for establishing a case record would start at the time that the option to decline services is offered and the time frame for the enforcement of support obligations would begin at the time the delinquency occurs; and

(4) The absence of a written application for the enforcement of a child support obligation could not be construed to eliminate the requirements for: (a) an application for requests for other services; and (b) compliance by the State agency to the time frames corresponding to those services.

As a condition of the granting of the waiver, the State agency would be required to perform a study on the cost-effectiveness of delinquency monitoring and submit it by December 31, 1991 to the Secretary of Health and Human Services and Congress. The study should use an experimental design with random assignment between experimental and control groups and must be performed with State funds only.

The cost of the project shall not exceed the lesser of \$500,000; and 66 percent of expenditures used to carry out the project.

The waiver would be effective January 1, 1991 through September 30, 1991.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828, modified to require that the evaluation of the demonstration project must be conducted in accordance with such criteria as the Secretary may establish, in consultation with one or more representatives of organizations representing child support administrators, the General Accounting Office, the State of Texas, and such other individuals and organizations with experience in the evaluation of child support programs as the Secretary may designate. The Secretary must establish the criteria no later than February 1, 1991. The cost of the evaluation would be shared by the Federal government at the 66 percent child support matching rate. The waiver may be extended for a period of up to two years.

B. Chapter 2—Unemployment Compensation

1. EXTENSION AND MODIFICATION OF THE "REED ACT"

(Section 5021 of the Conference Agreement)

Present law

The "Reed Act", named after the Honorable Daniel A. Reed (R., N.Y.), Chairman of the Committee on Ways and Means when the law was passed in 1954, allows excess Federal unemployment taxes, which occur when the three Federal accounts of the Unemployment Trust Fund overflow, to be used for administrative purposes or benefits by the States. It begins to expire over a three-year period beginning July 1, 1991.

Since the "Reed Act" was enacted in 1954, overflows have occurred only in 1956, 1957 and 1958. These additional funds were available to be appropriated by State legislatures and could be used for administration or benefits. Although much of these funds have been spent for benefits, \$52.3 million remained in the accounts of 35 States at the beginning of 1990. Under the Administration's projections, another overflow would probably not occur until 1997.

Under present law, any future excess Federal unemployment taxes would be distributed to the State accounts in proportion to the State shares of total wages subject to State unemployment taxes. States with relatively high State taxable wage bases and tax

rates would tend to receive proportionately more than States with relatively low taxable wage bases and tax rates.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, contains a provision which would make the "Reed Act" permanent. This would give States the authority to use funds that eventually overflow the Federal accounts of the unemployment trust fund for administrative purposes or benefits. In addition, it would modify the distribution formula so that any overflow would be distributed to the State accounts in the unemployment trust fund in proportion to each State's share of wages subject to Federal unemployment taxes paid in the prior calendar year instead of State taxable wages. States would be required to account for the "Reed Act" funds in accordance with standards set by the Secretary of Labor.

The provision would take effect on the date of enactment.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

2. PROHIBITION ON COLLATERAL ESTOPPEL

Present law

Currently, 14 States prohibit courts from using quasi-judicial decisions reached in unemployment compensation hearings to stop lawsuits on related employment issues, such as wrongful discharge from a job. This judicial doctrine is called "collateral estoppel". Federal law has no provision. In the remaining 39 jurisdictions, courts may use this doctrine to stop lawsuits on other employment issues.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision which would require State unemployment compensation laws to prohibit courts from stopping lawsuit on related employment issues based on a decision made in an unemployment compensation hearing.

The provision would take effect on October 1, 1991, except in the case of a State the legislature of which has not been in session for at least 30 calendar days (whether or not successive) between the date of the enactment of this Act and October 1, 1991, such amendments shall take effect 30 calendar days after the first day on which such legislature is in session on or after October 1, 1991.)

Senate amendment

No provision.

Conference agreement

The conference agreement follows the Senate amendment, i.e., no provision.

C. Chapter 3—Supplemental Security Income

1. TREATMENT OF VICTIMS' COMPENSATION PAYMENTS

(Section 5031 of the Conference Agreement)

Present law

Under present law, amounts received from victims' assistance funds are included as income or assets for purposes of determining eligibility and benefits for SSI.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision that excludes from income for purposes of determining SSI eligibility and benefits any payment received from a State-administered victims' compensation fund.

In addition, any amount received from a State victims' compensation fund, to the extent that it represents compensation for expenses incurred or losses suffered as a result of a crime, shall be excluded from resources for the 9-month period beginning after the month in which it was received.

No person awarded victims' compensation, who was otherwise eligible for SSI and who refused to accept such compensation, would be considered ineligible for SSI as a result of such refusal.

The provision would take effect in the month beginning 6 months after the date of enactment.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

2. ELIMINATE THE AGE LIMIT ON SECTION 1619 ELIGIBILITY

(Section 5032 of the Conference Agreement)

Present law

To be eligible for the Medicaid-only benefit under the section 1619 work incentive provisions an individual must be under 65 years old.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6010 of the Senate amendment)

The provision would eliminate this age limit and would be effective upon enactment.

Conference agreement

The conference agreement follows the Senate amendment, effective with respect to benefits for months beginning on or after the first day of the sixth calendar month following the month of enactment.

3. TREATMENT OF IMPAIRMENT-RELATED WORK EXPENSES

(Section 5033 of the Conference Agreement)

Present law

Impairment-related work expenses (IRWE) are excluded from a disabled individual's earnings for determinations of: (1) whether earnings constitute "substantial gainful activity;" (2) the benefit amount of an eligible disabled individual; and (3) continuing eligibility on the basis of income.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6011 of the Senate amendment)

The proposal would exclude impairment-related work expenses from income in determining initial eligibility and reeligibility for SSI benefits, and in determining State supplementary payments.

The provision would take effect four months following the month of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

4. TREAT CERTAIN ROYALTIES AND HONORARIA AS EARNED INCOME

(Section 5034 of the Conference Agreement)

Present law

Under present law, royalties received are considered unearned income under the SSI program unless they are from self-employment in a royalty-related trade or business. Honoraria are also considered unearned income. After the first \$20 of unearned income in a month is disregarded, this results in a dollar-for-dollar loss of SSI benefits.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6012 of the Senate amendment)

Any royalty which is earned in connection with the publication of an individual's work, or any honorarium which is received for services rendered would be treated as earned income for purposes of SSI eligibility and benefit determination. This would mean that

income from these sources would be disregarded to the same extent that income from other types of earnings is disregarded (i.e., the first \$65 of monthly earnings plus 50 percent of additional earnings).

The effective date for the provision would be the eighteenth month beginning after the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment, effective the thirteenth month beginning after the date of enactment.

5. STATE RELOCATION ASSISTANCE NOT COUNTED AS INCOME OR RESOURCES

(Section 5034 of the Conference Agreement)

Present law

The Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 excludes from income and resources any relocation assistance provided under the Act to individuals receiving Federal assistance, including SSI. Relocation assistance is paid when individuals are required to move by the Government. For example, the Government might need their land for a public building or highway or they might need to move because toxic wastes were discovered on the site. Under SSI, relocation assistance from any other source is considered income in the month received, and resources thereafter.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision to exclude from income and resources State relocation assistance.

The provision would take effect in the month beginning 6 months after the date of enactment.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828, modified to provide that State relocation assistance payments will be excluded from resources for no more than 9 months. In addition, the provision would be in effect for only three years.

6. EVALUATION OF CHILD'S DISABILITY BY PEDIATRICIANS

(Section 5036 of the Conference Agreement)

Present law

Present law does not require that a pediatrician or other qualified specialist be involved in the evaluation of a child's disability case.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6013 of Senate amendment)

The provision would require the Secretary of Health and Human Services to make reasonable efforts to ensure that a qualified pediatrician or other specialist in a field of medicine appropriate to the disability of the child evaluate the child's disability for purposes of determining eligibility for SSI.

The provision would take effect in the sixth month beginning after the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

7. REIMBURSEMENT FOR VOCATIONAL REHABILITATION SERVICES

(Section 5037 of the Conference Agreement)

Present law

The Secretary of HHS is required to refer blind and disabled individuals who are receiving SSI benefits to State vocational rehabilitation agencies and is authorized to reimburse these agencies for the reasonable and necessary costs of the vocational rehabilitation services that are provided to recipients under certain specified conditions. Reimbursement is not allowable with respect to services provided in months for which individuals were not receiving cash benefits but were eligible for Medicaid because they were in "special status" under 1619(b), were in suspended benefit status, or were receiving Federally administered State supplementary payments but not Federal SSI benefits.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6015 of Senate amendment)

The provision would implement a recommendation of the Disability Advisory Council to authorize reimbursement for vocational rehabilitation services provided in months for which individuals were in "special status" under section 1619(b), were in suspended benefit status, or were receiving Federally administered State supplementary payments.

The provision would take effect on the date of enactment and would apply to claims for reimbursement pending on or after the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

8. PRESUMPTIVE ELIGIBILITY TIME PERIOD

(Section 5038 of the Conference Agreement)

Present law

The Social Security Administration can presume eligibility for up to 3 months while processing applications for SSI on the basis of disability or blindness. If the process takes longer than 3 months, those ultimately eligible for benefits after three months receive back payments. In 1989, the Social Security Administration estimates that the final decision on eligibility took longer than 3 months in 31 percent of the cases where presumptive eligibility had been granted. Those who are determined to be ineligible are not required to repay the benefits they received while SSA presumed their eligibility.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision to extend the period of presumptive eligibility from 3 to 6 months.

The provision is effective upon enactment.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828, effective in the month beginning six months after enactment.

9. CONTINUING DISABILITY AND BLINDNESS REVIEWS

(Section 5039 of the Conference Agreement)

Present law

SSI recipients can participate in the work incentive provisions of section 1619 by earning amounts up to the level at which benefits cease (\$857 per month for single persons). Even if they are no longer eligible for cash benefits, they can continue to receive Medicaid.

Participants in the work incentive provision are subject to continuing disability or blindness review at certain times: (1) within 12 months of initial eligibility for the work incentive provisions; (2) promptly when an individual's earnings alone would have made him ineligible for cash assistance or Medicaid for the prior 12 months under section 1619 and he has become eligible again for either Medicaid or cash assistance.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision which permits continuing disability reviews no more than once every 12 months. The provision is effective upon enactment.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

10. CONCURRENT APPLICATIONS FOR SSI AND FOOD STAMPS

(Section 5040 of the Conference Agreement)

Present law

Public law 99-570, the Anti-Drug Abuse Act of 1986, amended the Social Security Act to require the Secretaries of HHS and Agriculture to develop a procedure to allow institutionalized individuals who are about to be released to make a single application for both SSI and food stamp benefits.

House bill

No provision.

Senate amendment (Section 6014 of Senate amendment)

Under this provision, the Secretary of HHS could either: (1) use a single application form for the food stamp and SSI programs; or (2) take concurrent applications for the SSI and food stamp programs.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

11. DISREGARD OF TRUST CONTRIBUTIONS

(Section 5041 of the Conference Agreement)

Present law

The term "trust" is not defined in either SSI law or regulations. SSI policy, as expressed in the program's operating manual, is to treat a trust as a resource when an individual owns the assets in the trust and, acting on his own behalf or through an agent (such as a representative payee for SSI benefits), has the legal right to use them for his own food, clothing, or shelter. If, however, the individual does not have the legal authority to access trust assets for his own food, clothing, or shelter (e.g., there is an intervening trustee), the trust is not considered a resource.

Cash payments made to an individual, including those from a trust (regardless of whether the trust is considered a resource), are considered income in the month received. Noncash payments for food, clothing, or shelter are also considered income. However, there are special rules under which noncash payments are presumed to have a maximum value of one-third of the Federal SSI monthly benefit amount, plus a \$20-a-month income exclusion. If a person can show that any in-kind support and maintenance provided is less than the "presumed value," the lesser amount is considered income. Thus, any cash or noncash payment for food, clothing,

or shelter affects SSI benefits and eligibility status. However, under SSA policy, a payment for certain social, medical, educational, transportation, or other services does not count as income, and does not affect SSI benefits or eligibility status.

House bill

No provision.

Senate amendment (Sections 6016-6018 of Senate amendment)

The SSI statute would be amended to specify that a trust established for an SSI recipient to which the recipient does not have legal access would not be counted as a resource, and certain non-cash contributions to a recipient would not be counted as income. In addition, the Secretary of HHS would be required to inform the family of a child who is awarded a retroactive payment as the result of the decision of the Supreme Court in *Sullivan v. Zebley* of the implications of such payments for SSI eligibility, that the family may be able to place the payment in a trust for the benefit of the child, and that legal assistance may be available. This information need not be provided in the form of a separate notice, but may be included in the notice of award of the retroactive payment.

Conference agreement

The conference agreement includes the Senate amendment requiring the Secretary to inform the family of a child who is awarded a retroactive payment as the result of the decision of the Supreme Court in *Sullivan v. Zebley* that the family may be able to place the payment in a trust for the benefit of the child.

The conference agreement does not include the Senate amendment with respect to the establishment of trusts. However, the managers recognize that it is important for SSI applicants and recipients to understand how different forms of income and resources are treated under the program, in order that they and their families can plan accordingly. They therefore intend that hearings be held during the 102nd Congress to address such issues as: whether statutory language should be enacted to specify the conditions under which funds placed in a trust may be excluded from countable income and resources; whether any limits should be placed on the amounts that can be placed in trust; and the purposes for which trust funds may be expended without affecting SSI eligibility and benefits. The omission of the Senate provision from the conference agreement is not intended in any way to change current SSA policy with respect to trusts.

D. Chapter 4—Aid to Families With Dependent Children

1. STATE OPTION TO REQUIRE MONTHLY REPORTING AND RETROSPECTIVE BUDGETING

(Section 5051 of the Conference Agreement)

Present law

Under section 402(a)(14) of the Social Security Act, States must require families with earned income or a recent work history to

provide a monthly report on: (1) income and family composition during the prior month; and (2) estimates of the income and resources anticipated in the current or future months. With the approval of the Secretary, a State may select categories of these families to report at less frequent intervals, if monthly reporting is not cost effective.

AFDC eligibility and benefits are determined monthly. Generally, a family's eligibility for and amount of aid for a month are based on the family's income, composition and resources in that month. However, under section 402(a)(13) of the Social Security Act, for families who are subject to monthly reporting requirements, States are required to calculate benefits based upon retrospective budgeting. Under retrospective budgeting, although eligibility is based on the family's circumstances in the current month, payment amounts are based on the family's income in the first or second month preceding the current month.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6020 of Senate amendment)

The provision would give States the option of specifying from which categories of families, if any, monthly reports will be required. If the State exercises the option, it must describe in its State plan the categories subject to the reporting requirement. Further, the State may choose to apply the retrospective budgeting technique to any one or more of the categories to whom the reporting requirement applies.

The provision would take effect with respect to reports pertaining to, or aid payable for, months after September 1990.

Conference agreement

The conference agreement follows the Senate amendment.

2. TREATMENT OF FOSTER CARE MAINTENANCE PAYMENTS AND ADOPTION ASSISTANCE

(Section 5052 of the Conference Agreement)

Present law

Prior to October 1, 1984, a child receiving State or Federal foster care maintenance payments or adoption assistance did not have to be included in the AFDC family unit, and the income and resources of the child did not count as the income and resources of the AFDC family. A family unit rule implemented as part of the Deficit Reduction Act of 1984, however, required that any parent or sibling of a dependent child be included in the AFDC unit. This rule applied to any sibling receiving foster care or adoption assistance.

The Tax Reform Act of 1986 amended AFDC law retroactively to October 1, 1984 to provide that, in determining a family's eligibility for or amount of AFDC benefits, a child receiving foster care maintenance payments under title IV-E would not be regarded as a

member of the family, and the income and resources of the child would not be counted as the income and resources of the family (section 478 of the Social Security Act).

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6021 of Senate amendment)

A child receiving State and/or local foster care maintenance payments would not be regarded as a member of an AFDC family for purposes of determining a family's eligibility for or amount of AFDC benefits, and the child's income and resources would not be counted as the income and resources of the family.

Further, a child receiving adoption assistance payments under title IV-E, or State and/or local adoption assistance payments, would not be regarded as a member of an AFDC family for purposes of determining a family's eligibility for or amount of AFDC benefits, and the child's income and resources would not be counted as the income and resources of the family, unless this would result in lower benefits for the family.

The provision would also move the section 478 provision, as amended, from title IV-E of the Social Security Act to title IV-A.

The provision would take effect in the month beginning six months after the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

3. ELIMINATING THE USE OF THE TERM "LEGAL GUARDIAN"

(Section 5053 of the Conference Agreement)

Present law

Section 402(a)(39) of the Social Security Act requires that, in determining AFDC benefits for a dependent child whose parent or legal guardian is under the age of 18, the State agency must include the income of the minor parent's own parents or legal guardians who are living in the same home.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6022 of Senate amendment)

The provision would delete all references to legal guardians.

Legal guardianship is not relevant to eligibility determination or the deeming of income under the AFDC program. For example, the use of the term "legal guardian" in the first instance is irrelevant since, even if such a guardian were appointed, the child would not be eligible for AFDC unless living with a relative specified in section 406 of the Social Security Act.

The use of the term "legal guardian" in the second instance is also inappropriate in the context of the AFDC statute. Unlike the parent-child relationship, legal guardianship has not been a basis for attributing income to AFDC beneficiaries. Using legal guardianship as a source of attributed income in three-generation families creates unequal treatment under the program. For example, if a minor child is living with an aunt who is her legal guardian, the aunt's income is not automatically attributed to the AFDC beneficiary; however, if the minor has a child, the guardian's income is included in the AFDC determination for the minor and her child.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

4. REPORTING OF CHILD ABUSE AND NEGLECT

(Section 5054 of the Conference Agreement)

Present law

Under current law, both the title IV-A (AFDC) and title IV-E (foster care and adoption assistance) State plan requirements stipulate that State agencies must report to appropriate court or law enforcement agencies instances of a child receiving program aid who is residing in a home that is unsuitable because the child is subject to abuse, neglect or exploitation (sections 402(a)(16) and 471(a)(9) of the Social Security Act).

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6023 of Senate amendment)

The provision would amend the AFDC, foster care and adoption assistance State plan requirements to require that each State agency report, to an appropriate agency or official, known or suspected instances of child abuse and neglect of a child receiving program aid. This would include instances of physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment under circumstances which indicate that the child's health or welfare is threatened. The State agency would also be required to provide such information with respect to the situation as it may have.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment, effective for months beginning six months after enactment.

5. PERMISSIBLE USES OF AFDC INFORMATION

(Section 5055 of the Conference Agreement)

Present law

Section 402(a)(9) of the Social Security Act restricts the use or disclosure of information about AFDC applicants and recipients to purposes directly connected with: (1) the administration of the AFDC program or several other specified Social Security Act programs; (2) any investigation, prosecution, or criminal or civil proceeding conducted in connection with such programs; (3) the administration of any other Federal or Federally-assisted program providing assistance or services to individuals on the basis of need; and (4) any audit of such programs.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6024 of Senate amendment)

The provision would add an explicit reference to title IV-E, the foster care and adoption assistance programs, to the list of programs for which information about AFDC applicants and recipients may be made available.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

6. REPATRIATION

(Section 5056 of the Conference Agreement)

Present law

Section 1113 of the Social Security Act authorizes the Secretary to provide temporary assistance to U.S. citizens and their dependents if they: (1) have returned or been brought from a foreign country to the U.S. because of destitution or illness, or war, threat of war, invasion or similar crisis; and (2) are without resources.

Prior to June, 1990, the maximum amount of temporary assistance that could be provided in one fiscal year equaled \$300,000. In June, 1990, the Secretary requested that the \$300,000 limit be increased to \$1 million, to accommodate the repatriation of several hundred Americans from Liberia. This increase was enacted in P.L. 101-382. According to the Secretary, the subsequent Iraqi invasion of Kuwait has placed new and unpredictable demands on the repatriation program. The Secretary expects the resulting program costs to exceed \$1 million.

House bill

No provision. (H.R. 5828, as reported by the Ways and Means Committee, includes a provision similar to the Senate amendment.)

Senate amendment (Section 6025 of Senate amendment)

The provision temporarily repeals the \$1 million spending cap for the repatriation program for fiscal years 1990 and 1991, and permits HHS to receive gifts from those wishing to contribute assistance to repatriated Americans through the repatriation program.

The provision would take effect for fiscal years beginning after September 30, 1989.

Conference Agreement

The conference agreement follows the Senate amendment.

7. CHILDREN'S COMMISSION REPORTING DATE

(Section 5057 of the Conference Agreement)

Present law

The National Commission on Children is directed to study and recommend to the President and the Congress ways to improve the well-being of children. P.L. 101-239 included an amendment to the original legislation that was intended to establish a final reporting date for the Commission of March 31, 1991. The amendment as enacted, however, includes a technical error.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6029 of Senate amendment)

The statute would be corrected to clarify that the final reporting date for the Commission is March 31, 1991.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

8. MORATORIUM ON FINAL REGULATIONS FOR EMERGENCY ASSISTANCE

(Section 5058 of the Conference Agreement)

Present law

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) included a provision stating that any final regulation which would change any policy in effect immediately before the date of the enactment of that Act with respect to the use of emergency assistance or special needs funds under the AFDC program could not take effect before October 1, 1990. In addition, the Secretary could not otherwise modify any policy with respect to the use of emergency assistance or special needs funds before October 1, 1990.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision similar to the Senate amendment.)

Senate amendment (Section 6032 of Senate amendment)

The date on prohibition of issuance of final regulations would be extended to October 1, 1991.

Conference agreement

The conference agreement would extend the prohibition of issuance of final regulations, and the prohibition on modifying current policy, to October 1, 1991.

9. MINNESOTA FAMILY INVESTMENT PLAN

(Section 5059 of the Conference Agreement)

Present law

The Omnibus Budget Reconciliation Act of 1989 permits the State of Minnesota to conduct a demonstration of the effectiveness of the Minnesota Family Investment Plan (MFIP). Under the demonstration, the State of Minnesota plans to determine whether its Family Investment Plan helps families to care for their children more effectively than do the AFDC and JOBS programs, as currently structured.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision which makes a series of technical changes that are necessary for the State to implement its Family Investment Plan.

The provision would take effect on the date of enactment.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

10. TECHNICAL AMENDMENT TO ALLOW GOOD CAUSE EXCEPTION

(Section 5060 of the Conference Agreement)

Present law

Under current law, as a condition of eligibility for AFDC, a parent must cooperate with the child support enforcement (IV-D) agency in establishing paternity, and in obtaining and enforcing a support order unless there is "good cause" for refusal. "Good cause" includes such factors as reasonable belief that cooperation could result in physical or emotional harm to the child or caretaker relative, and other factors established by regulation. The Family Support Act of 1988 established a similar requirement for cooperation with the IV-D agency in order for a family to be eligible to receive child care transition benefits. However, the "good cause" exception was omitted.

House bill

No provision.

Senate amendment (Section 6026 of Senate amendment)

The good cause exception from cooperating with the IV-D agency would be made applicable to transitional child care benefits to make it consistent with the exception that applies to AFDC cash benefits.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

11. JOBS TECHNICAL CORRECTION REGARDING PENALTY FOR FAILURE TO PARTICIPATE

(Section 5061 of the Conference Agreement)

Present law

The Family Support Act of 1988 added a penalty provision to the AFDC statute (section 402(a)(19)(G)) that provides that if the principal earner (in the case of a family eligible on the basis of the unemployment of the principal earner (AFDC-UP)) fails without good cause to participate in the JOBS program as required, the needs of that individual will not be taken into account in determining the amount of the family's AFDC benefit. If the spouse is not participating, the needs of the spouse will also not be taken into account. The penalty does not apply to benefits on behalf of any child in the family. When this new penalty language was added, however, the language contained in section 407 imposing a penalty for any child in the family if the principal earner fails to participate in the JOBS program was not repealed.

House bill

No provision.

Senate amendment (Section 6027 of Senate amendment)

The statute would be clarified by repealing the penalty language in section 407 that requires a reduction in AFDC benefits on behalf of a child in an AFDC-UP family if the principal earner fails to participate in the JOBS program.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment, effective at the same time and in the same manner as the amendments made by title II of the Family Support Act of 1988 take effect.

12. TECHNICAL CORRECTION REGARDING AFDC-UP ELIGIBILITY REQUIREMENTS

(Section 5062 of the Conference Agreement)

Present law

Prior to October 1, 1990, participation in the Work Incentive (WIN) and Community Work Experience (CWEP) programs counted in the definition of "quarter of work" for purposes of qualifying a family for AFDC-UP. Title IV of the Family Support Act of 1988 amended the definition of "quarter of work" to include participation in JOBS, but deleted references to WIN and CWEP. The result is that beginning October 1, 1990, prior participation in WIN or CWEP will not count toward the "quarter of work" requirement for purposes of establishing eligibility for AFDC-UP.

House bill

No provision.

Senate amendment (Section 6028 of Senate amendment)

Section 407(d) would be amended to allow participation in WIN and CWEP prior to October 1990 to count toward the "quarter of work" requirement for purposes of AFDC-UP eligibility.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

13. COMMUNITY DEVELOPMENT DEMONSTRATION TECHNICAL CORRECTION

(Section 5063 of the Conference Agreement)

Present law

The Family Support Act of 1988 authorized the Secretary of HHS to enter into agreements with up to 10 nonprofit organizations (including community development corporations) for the purpose of conducting demonstration projects to create employment opportunities for certain low income individuals. The authorization for the demonstrations is \$6.5 million for each of fiscal years 1990, 1991, and 1992.

House bill

No provision.

Senate Amendment (Section 6030 of Senate amendment)

The statute would be clarified to specify that the Secretary could enter into agreements with up to 10 nonprofit organizations each year. There would be no increase in the authorization.

Conference agreement

The conference agreement follows the Senate amendment.

14. GAO STUDY OF JOBS FUNDING FOR INDIAN TRIBES

(Section 5064 of the Conference Agreement)

Present law

Under the Family Support Act of 1988, Indian tribes (or Alaska Native organizations) may apply to operate JOBS programs. The statute requires that, in order to be considered by the Secretary, an application for Federal funding must be made within six months after enactment of the Family Support Act.

If an application is approved, the Secretary may grant funds to the tribe or Alaska Native organization (without a non-Federal matching requirement) to operate a JOBS program. The amount of funds is based on the ratio of adult AFDC recipients in the tribe relative to the adult AFDC recipients in the State. (The State's cap is appropriately reduced.) Requirements of the JOBS program may be waived if the Secretary determines that they are inappropriate.

House bill

No provision.

Senate amendment (Section 6031 of Senate amendment)

The bill would direct the General Accounting Office to conduct a study of how the provisions with respect to Indian tribes and Alaska Native organizations have been implemented by the Secretary and by such tribes and organizations, to describe any problems that may have been experienced in implementing the provisions, to determine to the extent possible the effectiveness of JOBS programs that are being operated by Indian tribes and Alaska Native organizations, and to make recommendations as to any legislative or administrative changes that could be made to improve the effectiveness of such programs.

Conference agreement

The conference agreement follows the Senate amendment.

E. Chapter 5—Child Welfare and Foster Care

I. ACCOUNTING FOR ADMINISTRATIVE COSTS

(Section 5071 of the Conference Agreement)

Present law

States are entitled to Federal reimbursement at a rate of 50 percent for expenditures made for the proper and efficient administration of the State title IV-E plan.

Under current law and regulation, Federal matching for administrative costs includes matching for activities that involve placement of the child in foster care, as well as what are ordinarily considered administrative "overhead" costs. These include activities related to child protections mandated by the Child Welfare and Adoption Assistance Amendments of 1980, such as: referral to services at time of intake; preparation for, and participation in, judicial determinations; development of a case plan for the child; periodic

reviews of the child's case plan; and case management and supervision.

Although there are no official program data showing what portion of administrative costs go for child placement activities as opposed to ordinary administrative overhead, the Inspector General has estimated that only about 20 percent of foster care administrative costs represent what are traditionally considered administrative overhead expenses.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision similar to the Senate amendment.)

Senate amendment (Section 6040 of Senate amendment)

Title IV-E would be amended to specifically add "child placement services" as activities for which States are entitled to receive Federal reimbursement. This is not intended in any way to change the type of activities for which States are currently allowed to claim Federal reimbursement as an administrative cost under title IV-E. In order to provide the Congress with more specific information on how these child placement and administrative matching funds are being spent, the Congress expects that the Secretary will develop and establish uniform definitions for the activities reimbursable as child placement services and administration, and will require the States to account for expenditures according to these activities.

The provision would take effect on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

2. SECTION 427 TRIENNIAL REVIEWS

(Section 5072 of the Conference Agreement)

Present law

Public Law 96-272, the Adoption Assistance and Child Welfare Amendments of 1980, was designed to provide financial incentives to the States to implement and operate a set of services and procedures to prevent the unnecessary removal of children from their home, prevent extended stays in foster care, and ensure that efforts are made to reunify children with their families or place them for adoption. The services and procedures are outlined in section 427 of the Social Security Act.

According to the HHS Section 427 Review Handbook, to verify compliance with section 427 requirements, HHS conducts a two-stage review. The first stage is an administrative review which determines whether States have developed policy and procedures to implement the section 427 requirements for all children in foster care under the responsibility of the State. The second stage of the review is the case record survey which confirms that the policies are being implemented throughout the State.

An initial review is conducted for the fiscal year in which the State first certifies its eligibility. If a State meets the initial review,

a subsequent review is conducted for the following fiscal year. States that meet the requirements of this subsequent review will be reviewed for the third fiscal year following the fiscal year for which the subsequent review was conducted, and every third year thereafter. This is known as the triennial review. The case record survey must confirm that the section 427 foster care protections are provided for at least 66% of the children in the initial review, 80% in the subsequent review, and 90% in the triennial review. If a State does not meet the established standards for the year under review, the review is conducted each succeeding year until eligibility is established.

The Omnibus Budget Reconciliation Act of 1989 included a provision which prohibited the Secretary from, before October 1, 1990, reducing payments to, seeking repayment from, or withholding any payments from any State as a result of a disallowance determination made in connection with a triennial review of State compliance with the section 427 foster care protections, for any fiscal year preceding fiscal year 1991.

HHS has convened a department-wide task force to review and revise the current section 427 review process. Draft regulations are expected during calendar year 1991.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6041 of Senate amendment)

The provision would extend the current prohibition on reducing payments to, seeking repayment from, or withholding payments from States to October 1, 1991, to apply to any determinations made in connection with a triennial review for any Federal fiscal year preceding fiscal year 1992.

The provision would take effect on October 1, 1990.

Conference agreement

The conference agreement follows the Senate amendment.

3. INDEPENDENT LIVING TO AGE 21 AT STATE OPTION

(Section 5073 of the Conference Agreement)

Present law

The Independent Living Program is a State entitlement program under title IV-E designed to help ease the transition of foster children age 16 and older to independent living. Independent living services may include school and vocational training, living skills training, housing location and career planning assistance, counseling, service coordination, outreach, and the development of plans for independent living as part of the case plan.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6042 of Senate amendment)

The statute would be amended to allow States to include youths who have been "discharged" from the foster care system in services provided under the independent living program, up to age 21.

The provision would take effect on October 1, 1990.

Conference agreement

The conference agreement follows the Senate amendment.

F. Chapter 6—Grants to States for Child Care

1. GRANTS TO STATES FOR CHILD CARE

(Section 5081 of the Conference Agreement)

Present law

Federal matching is available to States on an entitlement basis to provide child care for AFDC parents who are participating in the JOBS program, and to provide child care for a period of 12 months after the family loses eligibility for AFDC as a result of increased hours of, or increased income from, employment.

House bill

No provision.

Senate amendment (Section 6043 of Senate amendment)

Funding for the existing title IV child care program would be increased to provide \$65 million for each of fiscal years 1991-1995 to enable States to provide child care to low income non-AFDC families that the State determines: (1) need such care in order to work; and (2) would otherwise be at risk of becoming dependent upon AFDC.

Capped entitlement funds would be allocated on the basis of child population. Rules relating to Federal matching rates, reimbursement, standards, and fee schedules would remain the same as in current law. States would be required to report annually to the Secretary on child care activities carried out with funds under this entitlement.

In addition, the authorization for grants (enacted in the Family Support Act of 1988) to enable States to improve their child care licensing and registration requirements and procedures, and to monitor child care provided to children receiving AFDC, would be extended to provide \$35 million for each of fiscal years 1992, 1993, and 1994 for these purposes.

Conference agreement

The conference agreement follows the Senate amendment, modified to provide \$300 million for each of fiscal years 1991 through 1995. In addition, the conference agreement provides that all child

care providers that receive funds under this provision must be licensed, regulated, or registered. As in the Senate amendment, all child care paid for with these funds must meet applicable standards of State and local law. However, there would be no requirement that individuals who provide care solely to members of their family be licensed, regulated, or registered.

It is the intent of the conferees that States will have maximum flexibility in determining how these new grant funds are used.

The \$35 million currently authorized for grants to improve licensing and registration requirements and procedures, and to monitor child care provided to children of AFDC recipients, is increased to \$50 million, beginning in fiscal year 1992 and extending through fiscal year 1994. One-half of these funds are earmarked for training child care providers. The remainder must be used for improving licensing and registration requirements and procedures, and for enforcement. Activities under the grant would apply to all children receiving services under title IV-A, not just those receiving AFDC.

2. CHILD CARE AND DEVELOPMENT BLOCK GRANT

(Section 5082 of the Conference Agreement)

The Conference report includes the Child Care and Development Block Grant Act of 1990. The purpose of this block grant program is to increase the availability, affordability, and quality of child care. The provision provides financial assistance to low-income, working families to help them find and afford quality child care services for their children. It also contains provisions to enhance the quality and increase the supply of child care available to all parents, including those who receive no financial assistance under the block grant program.

More specifically, the purpose of this block grant program is to give parents a variety of options in addressing family child care needs. Additionally, this provision is intended to build on and to strengthen the role of the family by seeking to ensure that parents are not forced by the lack of available programs or financial resources to place a child in an unsafe or unhealthy child care arrangement; to promote the availability and diversity of quality child care services to expand child care options available to all families who need such services; to provide assistance to families whose financial resources are not sufficient to enable such families to pay the full cost of necessary child care; to improve the productivity of parents in the labor force by lessening the stresses related to the absence of adequate child care services; and to provide assistance to states and Indian tribes to improve the quality of, and coordination among, child care programs and early childhood development programs.

The Conference agreement authorizes \$750,000,000 for fiscal year 1991, \$825,000,000 for fiscal year 1992, \$925,000,000 for fiscal year 1993, and such sums as may be necessary for fiscal years 1994 and 1995. Block grant funds are provided to states in accordance with a formula based on numbers of young children and of school lunch recipients.

Use of block grant funds for child care services

Each state shall use 75 percent of block grant funds for direct assistance to parents for child care services and to increase the supply and to improve the quality of child care. Block grant funds may only be used by the states for child care services and for activities which directly improve the availability and quality of care for families assisted under the Act. Quality activities eligible for funds under section 658E(c)(3)(B)(ii) should be the same type of quality activities specified in the quality reservation in section 658G. It is the conferees' intent that a preponderance of the block grant funds be spent specifically on child care services and a minimum amount on other authorized activities.

The managers believe that parents should have the greatest choice possible in selecting child care for their children. Thus, parents assisted under section 658(c)(3)(B) would have complete discretion to choose from a wide range of child care arrangements, including care by relatives, churches, synagogues, family providers, centers, schools, and employers. All such providers may be paid through grants or contracts or through certificates provided to the parent. A parent assisted under section 658E(c)(3)(B) must be given the option of receiving a certificate.

Use of 25 percent reserve of funds

Each state shall reserve 25 percent of block grant funds for grants and contracts to providers of early childhood development or before- and after-school services, or both, and for activities to improve the quality of child care. Of the 25 percent reserve, not less than seventy-five percent of this reserve shall be allocated to early childhood development and before- and after-school care activities; not less than twenty percent for quality activities with the remaining five percent to be used for either purpose. A state may assign responsibility for the administration of early childhood development and latchkey programs to an agency other than the lead agency, such as an agency that has experience in the administration of existing education or preschool programs. Eligible quality activities include establishing or expanding resource and referral programs; making grants or loans to providers to assist them in meeting state and local child care standards; improving the monitoring of compliance with, and enforcement of, state standards and licensing and regulatory requirements; providing training and technical assistance; and improving salaries and other compensation paid to child care staff.

General provisions

Families eligible for assistance for child care are those who earn less than 75 percent of the state median income and who have children under age 13. The amount of assistance would be based on a sliding fee scale established by the state. Nothing in this subchapter is intended to prohibit the provision of services at no cost to families whose income is at or below the poverty level. Providers would receive payment at rates which would ensure equal access to services comparable to those provided to children whose care is not publicly subsidized.

Parental choice and involvement are further enhanced through provisions for unlimited parental access to children during the day and within the care setting, for parental complaint procedures and access to records of substantiated parental complaints, and for consumer education.

The managers intend that the determination whether any financial assistance provided under this subchapter, including a loan, grant or child care certificate, constitutes Federal financial assistance for purposes of title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681, et seq.), the Rehabilitation Act of 1973 (29 U.S.C. 794 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), all as amended, and the regulations issued thereunder, shall be made in accordance with those provisions. bb

To receive funds, a state shall submit a plan that includes: designation of a lead agency; local consultation regarding development of the plan; coordination with existing programs; use of funds for child care services, including early childhood education and before-and-after school care, and for activities related to quality and availability; supplement not supplant language; priority for very low income children and children with special needs; and use of a sliding fee scale. The managers intend that, to the maximum extent practicable, the lead agency be a state entity in existence on or before the date of enactment of this subchapter with experience in the administration of appropriate child care programs.

All eligible providers shall be licensed, regulated, or registered prior to payment and must comply with applicable state and local licensing and regulatory requirements. The state plan shall describe minimum health and safety requirements established by the state for all providers funded under this subchapter and ensure that such providers demonstrate compliance with these requirements. These health and safety requirements include the prevention and control of infectious diseases, building and physical premises safety, and a minimum health and safety training requirement appropriate to the provider setting. The state shall conduct a one-time review of state licensing and regulatory requirements and policies, unless the state has done so within three years prior to the date of enactment.

The state shall report to the Secretary of Health and Human Services annually on the use of funds under this subchapter; data on caregivers and children in care; activities to encourage public-private partnerships which promote business involvement in meeting child care needs; results of any review of state licensing and regulatory requirements; a rationale for any state actions to reduce the levels of state standards; state actions to improve the quality of care; and a description of standards in the state.

The Secretary will report to Congress annually on use of all Child Care and Development Block Grant Act funds in the states. The report will include a summary and analysis of the above data provided by the States to the Secretary and any recommendations to Congress on further steps necessary to improve access to quality and affordable child care.

II. SUBTITLE B—OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

1. MAKE PERMANENT THE CONTINUATION OF DISABILITY BENEFITS DURING APPEAL

(Section 5102 of the Conference Agreement)

Present law

A disability insurance (DI) beneficiary who is determined to be no longer disabled may appeal the determination sequentially through three appellate levels within the Social Security Administration (SSA): a reconsideration, usually conducted by the State Disability Determination Service that rendered the initial unfavorable determination; a hearing before an SSA administrative law judge (ALJ); and a review by a member of SSA's Appeals Council.

The beneficiary has the option of having his or her benefits continued through the hearing stage of appeal. If the earlier unfavorable determinations are upheld by the ALJ, the benefits are subject to recovery by the agency. (If an appeal is made in good faith, benefit recovery may be waived.) Medicare eligibility is also continued, but medicare benefits are not subject to recovery.

The Disability Reform Amendments of 1984 (P.L. 98-460) provided benefits through the hearing stage on a temporary basis. This provision was subsequently extended, most recently by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239). That Act extends the provision to appeals of termination decisions made on or before December 31, 1990. Under this latest extension, payments may continue through June 30, 1991 (i.e., through the July 1991 check).

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6050 of Senate amendment)

The Senate amendment would make the temporary provision permanent. Thus, on a permanent basis, beneficiaries would have the option of having their DI and medicare benefits continued through the hearing stage of appeal. As under current law, DI benefits would be subject to recovery where the ALJ upheld the earlier unfavorable decision, while medicare benefits would not be subject to subsequent recovery.

The provision would be effective upon enactment.

Conference agreement

The conference agreement follows the Senate amendment.

2. IMPROVEMENT OF THE DEFINITION OF DISABILITY APPLIED TO DISABLED WIDOW(ER)S

(Section 5103 of the Conference Agreement)

Present law

A widow(er) or surviving divorced spouse of a worker may be entitled to widow(er)'s benefits if he or she is age 60, or at any age if he or she is caring for the worker's child who is under age 16. A widow(er) or surviving divorced spouse with no child in care and who is under age 60 but is at least age 50 may be eligible for widow(er)'s benefits as a disabled widow(er).

Generally, disability is defined as an inability to engage in any substantial gainful activity (defined in regulations as earnings of more than \$500 per month, effective January 1, 1990) by reason of a physical or mental impairment. The impairment must be medically determinable and expected to last for not less than 12 months or to result in death. A person (other than a disabled widow(er)) may be determined to be disabled only if, due to this impairment, he or she is unable to engage in any kind of substantial gainful work, considering his or her age, education and work experience, which exists in the national economy.

The definition of disability which is applied to widow(er)s, however, is stricter than that which is applied to workers and to Supplemental Security Income (SSI) disability applicants. First, a widow(er) must have a disability severe enough to prevent him or her from engaging in "any gainful activity" (little or no earnings at all) rather than substantial gainful activity (ordinarily, earnings of more than \$500 per month). Second, for a disabled widow(er) the three vocational factors used in determining a worker's disability—age, education, and work experience—are not considered. Therefore, the disability must be established based on medical evidence alone.

Once SSA determines that an individual is disabled, there is a five-month waiting period before disability benefits are payable. Once disability benefits begin, there is a 24-month waiting period for entitlement to medicare benefits.

The stricter test of disability for disabled widow(er)s was established in the Social Security Amendments of 1967, which created this new entitlement to benefits. In explaining the reasons for the more restrictive rules, Ways and Means Committee Chairman Wilbur Mills stated on the House floor, "We wrote this provision of the bill very narrowly, because it represents a step into an unexplored area where cost potentials are an important consideration."

House bill

No provision. (H. R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6051 of Senate amendment)

Providing benefits to widow(er)s on the basis of disability has been found not to be a significant cost to the trust fund. Therefore, the provision would repeal the stricter definition of disability that

must be met by a disabled widow(er) age 50-59 in order to qualify for widow(er)'s benefits and instead apply the definition of disability used for workers. Widow(er)s who had been receiving SSI disability benefits prior to becoming eligible for disabled widow(er)'s benefits would be able to count the months beginning with the month they first received these benefits toward satisfying the five-month waiting period for social security disability benefits and the 24-month waiting period for medicare benefits. In addition, widow(er)s who receive SSI disability benefits prior to becoming entitled to disabled widow(er)'s benefits would not lose medicaid eligibility as a result of receiving a higher social security benefit, but only for so long as they are not entitled to medicare benefits.

The provision would be effective for benefits payable for months after December, 1990, but only on the basis of applications filed or pending on or after January 1, 1991. The Secretary would not be required to make a new determination of disability for widow(er)s receiving SSI or disabled worker's benefits prior to becoming entitled to disabled widow(er)'s benefits. SSA would be required, to the extent possible, to notify such individuals of their eligibility for disabled widow(er)'s benefits.

Conference agreement

The conference agreement follows the Senate amendment.

3. PAYMENT OF BENEFITS TO A CHILD ADOPTED BY A SURVIVING SPOUSE

(Section 5104 of the Conference Agreement)

Present law

A child adopted by the surviving spouse of a deceased worker must meet two tests in order to be entitled to benefits as a surviving child. First, adoption proceedings must have been initiated prior to the worker's death, or the adoption must have been completed within two years of the worker's death. Second, the child must have been living in the worker's home and cannot have been receiving support from any source other than the worker or the spouse (e.g., a foster care program) in the year prior to the worker's death.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6052 of Senate amendment)

A child adopted by the surviving spouse of a deceased worker would be entitled to survivor's benefits if the child either lived with the worker or received one-half support from the worker in the year prior to death. The requirements relating to the timing of the adoption would not be changed.

The provision would be effective with respect to benefits payable for months after December 1990, but only on the basis of applications filed on or after January 1, 1991.

Conference agreement

The conference agreement follows the Senate amendment.

4. IMPROVEMENTS IN THE REPRESENTATIVE PAYEE SYSTEM

(Section 5105 of the Conference Agreement)

Present law

Under current law, the Secretary of Health and Human Services may appoint a relative or some other person (known as a "representative payee") to receive social security or SSI benefit payments on behalf of a beneficiary whenever it appears to the Secretary that the appointment of a representative payee would be in the best interest of the beneficiary.

The Secretary is required to investigate each individual applying to be a representative payee either prior to, or within 45 days after, the Secretary certifies payment of benefits to that individual. Present law does not specify what shall be included in the investigation.

The Secretary is required to maintain a system of accountability monitoring under which each representative payee is required to report not less than annually regarding the use of the payments. The Secretary is required to review the reports and identify instances where payments are not being properly used.

Any individual convicted of a felony under section 208 or section 1632 of the Social Security Act may not be certified as a representative payee.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision that is similar to the Senate amendment, with minor and technical differences).

*Senate amendment (Section 6053 of Senate amendment)**a. Investigations of representative payee applicants*

During the investigation of the representative payee applicant, the Secretary would be required to: 1) require the representative payee applicant to submit documented proof of identity; 2) conduct a face-to-face interview with the representative payee applicant when practicable; 3) verify the social security account number or employer identification number of the representative payee applicant; 4) determine whether the representative payee applicant has been convicted of a social security felony under section 208 or section 1632 of the Social Security Act; and 5) determine whether the representative payee applicant had ever been dismissed as a representative payee for misuse of a beneficiary's funds. An individual who had been convicted of a felony under section 208 or section 1632, or dismissed as a representative payee for misuse of the benefit payment, would not be permitted to be certified as a representative payee on or after January 1, 1991. The Secretary would be permitted to issue regulations under which an exemption from the prohibition against certification in the case of misuse would be granted on a case-by-case basis, if the exemption would be in the

best interest of the beneficiary. The conferees intend that the exemption would be granted only in rare instances.

The Secretary would be required to: (1) terminate payments to a representative payee where the Secretary or court of law found that the representative payee had misused the benefit payments; (2) maintain a list of those terminated for misuse on or after January 1, 1991; and (3) provide such a list to local field offices. If the computer program necessary to maintain such a list is not developed by January 1, 1991, the list should be maintained manually. Under current SSA policy, misuse is defined as converting benefit payments for personal use, or otherwise diverting the payments in bad faith with a reckless indifference to the welfare and interests of the beneficiary. The conferees expect the Secretary to apply this definition under this provision.

The Secretary would be required to maintain a centralized, current file readily retrievable by all local SSA offices of: 1) the address and social security account number (or employer identification number) of each representative payee; and 2) the address and social security account number of each beneficiary for whom each representative payee is providing services as representative payee. In addition, local service offices would be required to maintain a list of all public agencies and community-based non-profit social service agencies qualified to serve as a representative payee in the area served by such office.

Current law prohibits any individual convicted of a felony under section 208 or section 1632 of the Social Security Act from serving as representative payee. The provision would require SSA to maintain a list of those convicted and make it readily available to local field offices.

b. Withholding of benefits

In cases where the Secretary is unable to find a representative payee, and the Secretary determines that it would cause the social security beneficiary or SSI recipient substantial harm to make direct payment, the Secretary would be permitted to withhold payment for up to one month. Not later than the expiration of the one month period, the Secretary would be required to begin direct payment to the beneficiary starting with the current month's benefit unless the beneficiary had been declared legally incompetent or was under age 15. Retroactive benefits would be withheld until a representative payee had been appointed or the Secretary determines a suitable representative payee could not be found. Retroactive benefits would be paid over such period as the Secretary determines is in the best interest of the beneficiary.

It is not the intention of the conferees to encourage SSA to withhold benefits from a beneficiary whom the Secretary has determined to need a representative payee. The beneficiary should be paid directly if at all possible, especially if the beneficiary had been using the benefit payment to meet immediate needs such as shelter, food and clothing.

The conferees do not wish SSA to view the one month withholding period as a routinely acceptable length of time in which to find a representative payee. The conferees expect SSA to make every

effort to find a qualified representative payee for an individual as quickly as possible.

The conferees recognize that in some cases (such as an unreported change of address) SSA may not be officially notified of the need to change a representative payee. The conferees intend that the 1-month period of suspension shall be measured from the point the Secretary first becomes aware that a representative payee issue exists, and shall consider the objective of this provision met so long as the Secretary takes prompt action to minimize interruption of benefits.

c. Limitations on the appointment of representative payee

An individual who is a creditor providing goods and services to an OASDI or SSI beneficiary for consideration would be precluded from serving as the beneficiary's representative payee with certain exceptions. The exceptions would include: (1) a relative who resides in the same household as the beneficiary; (2) a legal guardian or representative; (3) a facility licensed or certified under State or local law; (4) an administrator, owner, or employee of such facility if the beneficiary resides in the facility and the local social security office has made a good faith effort to locate an alternate representative payee; and (5) an individual whom the Secretary determines to be acceptable based on a written finding reached under established rules that require the individual to show to the satisfaction of the Secretary that he or she poses no risk to the beneficiary, that the individual's financial relationship with the beneficiary poses no substantial conflict of interest, and no other more suitable representative payee exists.

d. Appeal rights and notices

The beneficiary would have the right to: 1) appeal the Secretary's determination of the need for a representative payee; and 2) appeal the designation of a particular person to serve as representative payee. In appealing either the determination or the designation, the beneficiary (or the applicant in cases of initial entitlement) would have a right to review the evidence upon which the determination was based and to submit additional evidence to support the appeal.

The Secretary would be required to send a written notice of the determination of the need for a representative payee to the beneficiary (other than a child under age 18 living with his parents), and each person authorized to act on behalf of an individual who is legally incompetent or is a minor.

The provision would require that the notices be provided in advance of any benefits being paid to a representative payee. In addition, the notice must be clearly written and explain the beneficiary's rights in an easily understandable manner.

e. High-risk representative payees

The Secretary would be required to study and provide recommendations as to the feasibility and desirability of formulating stricter accounting requirements for all high-risk representative payees and providing for more stringent review of all accounting from such representative payees. The Secretary would be required to

define as high-risk representative payees: 1) non-relative representative payees who do not live with the beneficiary; 2) those who serve as a representative payee for five or more beneficiaries (under title II, title XVI or a combination thereof) and who are not related to them; 3) creditors of the beneficiary; and 4) any other group determined by the Secretary to be high-risk.

The purpose of the provision is to identify groups or individuals serving as representative payees who may be likely to misuse or improperly use benefit payments. At a minimum, the conferees expect SSA to examine board and care operators, nursing homes, and individuals who are not related to nor living with the beneficiary. The proposal does not apply to Federal or State governmental institutions.

f. Restitution of benefits

In cases where the negligent failure of the Secretary to investigate or monitor a representative payee results in misused benefits, the Secretary would be required to make repayment to the beneficiary. In addition, the Secretary would be required to make a good faith effort to obtain restitution of any misused funds.

g. Fee for representative payee services

Community-based non-profit social service agencies, in existence on October 1, 1988, which are bonded or licensed by their states and regularly serve as representative payees for five or more beneficiaries would be allowed to collect a monthly fee for representative payee services. The fee would be collected from the beneficiary's social security or SSI payment not to exceed the lesser of ten percent of the monthly benefit due or \$25.

The provision would sunset after three years. The Secretary would be required to keep track of the number and type of groups who participated under this provision and report back to the Committee on Ways and Means and the Committee on Finance at the end of two years.

In general, the provision would prohibit an agency which is a creditor of the beneficiary from serving as a representative payee but would require the Secretary to develop regulations whereby exceptions would be granted on a case by case basis if the exception is in the best interest of the beneficiary.

The term "community-based, non-profit, social service agencies" means non-profit social service agencies which are representative of communities or significant segments of communities and that regularly provide services for those in need. Guardian, Inc., of Calhoun County, Michigan, is an example of a non-profit organization which regularly provides representative payee services. The Salvation Army, Catholic Charities, and Lutheran Social Services are examples of agencies providing social services to the needy.

Qualified organizations which charge or collect, or make arrangements to charge or collect, a fee in excess of the maximum fee would be subject to a fine of not more than \$10,000.

Currently, SSA permits an individual serving as a representative payee to be reimbursed from the beneficiary's check for actual out-of-pocket expenses incurred on behalf of the beneficiary. These expenses include items such as stamps, envelopes, cab fare, or long-

distance phone calls. It is the intention of the conferees that such individual representative payees would continue to be reimbursed in this manner. The conferees do not intend these representative payees to receive any additional fee for services.

The General Accounting Office would be directed to conduct a study of the advantages and disadvantages of allowing qualified organizations that charge fees to serve as representative payees to individuals who receive social security and SSI benefits, and to report its finding to the Finance and Ways and Means Committees by January 1, 1993.

h. Studies and demonstration projects

(i) The Secretary would be required to enter into demonstration arrangements with not fewer than two states under which the Secretary would make readily available to such states a list of all addresses where OASDI and SSI benefit payments are received by five or more unrelated beneficiaries. The Secretary would be required to make the information available to the state agencies primarily responsible for regulating care facilities or for providing adult or child protective services in the participating states.

The purpose of this demonstration project is to determine whether providing such information to the state protective service agencies would be useful in locating unlicensed board and care homes.

(ii) The Secretary would be required to study the feasibility of determining the type of representative payee applicant most likely to have a felony or misdemeanor conviction, the suitability of individuals with prior convictions to serve as representative payees, and the circumstances under which such applicants could be allowed to serve as representative payee.

The information obtained from this study would assist the Ways and Means and Finance Committees in determining whether there are circumstances under which an individual with a conviction should be permitted to serve as a representative payee.

(iii) The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Attorney General, would be required to study the feasibility of establishing and maintaining a list of the names and social security account numbers of those who have been convicted of social security or SSI check fraud violations under section 495 of title 18 of the U.S. Code. As part of the study, the Secretary would be required to consider the feasibility of providing such a list to social security field offices in order to assist claims representatives in the investigation of representative payee applicants. The Secretary would be required to report the results of the study, together with any recommendations, to the Committee on Ways and Means and the Committee on Finance no later than July 1, 1992.

Law enforcement agencies do not report violations under section 495 of title 18 of the U.S. Code to either SSA or the Department of Health and Human Services Inspector General. As a result, SSA is often unaware of arrests and convictions of individuals for violations under this section and therefore fails to

obtain restitution or to prevent those convicted of such violations from serving as representative payee.

(iv) The Secretary would be required to conduct a study with the Department of Veterans' Affairs of the feasibility of designating the Department of Veterans' Affairs as the lead agency for administering a representative payee program for dual recipients of Old Age Survivors and Disability Insurance or Supplemental Security Income benefits and veterans' benefits. The Secretary would be required to report to Congress on the feasibility of this arrangement within six months after enactment. In general, the provision would be effective July 1, 1991.

Conference agreement

The conference agreement follows the Senate amendment with minor and technical changes.

5. STREAMLINING OF THE ATTORNEY FEE PAYMENT PROCESS

(Section 5106 of the Conference Agreement)

Present law

Attorneys and other persons who represent claimants before the Social Security Administration (SSA) are permitted to collect fees for their services, subject to approval and limits set by SSA. By regulation, the representative must submit a fee petition detailing the number of hours spent on the case and requesting a specific fee. The Administrative Law Judge (ALJ) who heard the case is required to review the fee petition. If the fee requested is less than \$4,000, the ALJ has authority to approve or modify it. If the amount requested exceeds \$4,000, it must be reviewed and approved or modified by the regional Chief ALJ. Where the claimant is represented by an attorney and a favorable determination is made, SSA by statute withholds up to 25 percent of the claimant's past-due social security benefits and pays the attorney directly. In cases where the claimant is concurrently entitled to both past-due social security and Supplemental Security Income (SSI) benefits and the SSI benefits are paid first, the amount of past-due social security benefits payable is reduced by the amount of SSI benefits that would not have been paid if the social security benefits had been paid monthly when due rather than retroactively. In many such cases, this leaves little or no past-due social security benefits out of which to pay the attorney the approved fee.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision that is similar to the Senate amendment with minor and technical differences.)

Senate amendment (Section 6054 of Senate amendment)

The provision would generally replace the fee petition process with a streamlined process in which SSA would approve any fee agreement jointly submitted in writing and signed by the representative and the claimant if the Secretary's determination with respect to a claim for past-due benefits was favorable and if the

agreed-upon fee did not exceed a limit of 25 percent of the claimant's past-due benefits up to \$4,000. The \$4,000 limit could be increased periodically for inflation at the Secretary's discretion. If a fee was requested for a claim which did not meet the conditions for the streamlined approval process, it would be reviewed under the regular fee petition process.

A representative who is an attorney would be paid the approved fee out of the claimant's past-due social security benefits, prior to any reduction for previously-paid SSI benefits. However, if the attorney were awarded a fee in excess of 25 percent of the claimant's past-due social security benefits, the amount payable to the attorney out of the past-due social security benefits could not exceed 25 percent of these benefits.

The representative, the claimant, or the ALJ that heard the case would have the right to protest the approved fee. However, the ALJ could protest the approved fee only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest, or on the basis of evidence that the fee is clearly excessive for the services rendered. SSA would review any protested fee and approve, modify, or disallow it. If the ALJ that heard the case filed the protest, a different ALJ would review the fee.

It is not the conferees' intent that this process be used to establish regular review of fees at the ALJ level. The Committee wishes to emphasize that the protest of a fee amount by an ALJ is to be made only in cases where there is prima facie evidence that the fee is clearly excessive in light of the services rendered.

In addition, with respect to reimbursement for travel expenses of individuals who represent claimants, such reimbursement could not exceed the maximum amount that would be payable for travel to the site of the reconsideration interview or proceeding before an ALJ from a point within the geographical area served by the office having jurisdiction over the interview or proceeding.

With the exception of the provisions relating to direct payment of an attorney's fee out of past-due benefits, conforming changes would be made with respect to representation of SSI applicants.

The provision would be effective for determinations made on or after July 1, 1991, and reimbursement for travel costs incurred on or after April 1, 1991.

Conference agreement

The conference agreement follows the Senate amendment.

6. RES JUDICATA: APPEAL VERSUS REAPPLICATION

(Section 5107 of the Conference Agreement)

Present law

If a claimant for social security disability benefits successfully appeals an adverse determination by the Secretary, benefits can be paid retroactively for up to 12 months prior to the date of the original application.

If, however, instead of appealing, the claimant reappplies and is subsequently found to be disabled as of the date originally alleged,

there are circumstances where retroactive benefits would be limited to 12 months prior to the date of the subsequent application (rather than prior to the date of the first application). This occurs when SSA's "reopening rules" do not permit the original application to be reopened. (SSA's administrative policy permits a case to be reopened within 12 months of an initial determination for any reason; and within four years if there is new and material evidence or the original evidence clearly shows on its face that an error was made in the original decision.)

A reapplication, in lieu of an appeal, also could result in an outright denial of social security or Supplemental Security Income (SSI) benefits without consideration of an individual's medical condition. This occurs in the case of social security when: (i) the claimant's insured status runs out before the date of the original denial; and (ii) there is no new and material evidence and no facts or issues that were not considered in making the prior decision. In the case of SSI, this occurs when (ii) applies. In these situations, SSA applies the legal principle of *res judicata* to deny the subsequent claim. Under this principle—the use of which is prescribed by SSA regulations—SSA will not consider the same claim again and again.

Prior to May 1989, SSA's standard denial notice informed claimants that they could reapply at any time but did not explain the potential adverse consequences of reapplying versus appealing a denial. A May 1989 modification of this notice informs claimants that reapplying may result in a loss of benefits but does not mention the second problem described above, i.e., an outright denial of eligibility without further consideration of the evidence.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision that is identical to the Senate amendment.)

Senate amendment

When a claimant for social security or SSI benefits can demonstrate that he or she failed to appeal an adverse decision because of reliance on incorrect, incomplete, or misleading information provided by SSA, his or her failure to appeal could not serve as the basis for denial by the Secretary of a second application for any payment under title II or title XVI. This protection would apply to both initial denials and reconsiderations by the Secretary. The Secretary also would be required to include in all notices of denial a clear, simple description of the effect on possible entitlement to benefits of reapplying rather than filing an appeal.

The provision would apply to adverse determinations made on or after January 1, 1991.

Conference agreement

The conference agreement follows the Senate amendment, with an effective date of July 1, 1991.

7. SSA TELEPHONE ACCOUNTABILITY DEMONSTRATION PROJECTS

(Section 5108 of the Conference Agreement)

Present law

The Social Security Act is silent regarding telephone service provided by SSA. In practice, SSA currently operates 37 teleservice centers (TSCs) that respond to inquiries from the public. In addition to providing general program information, these TSCs can schedule appointments at local offices and provide individual service, including discussing a person's eligibility and taking specific actions regarding his or her benefits. In October 1988, the TSCs were integrated into a toll-free telephone network that covered 60 percent of the population. In October 1989, toll-free service was extended via the TSCs and four new mega-TSCs to the entire country. At the same time, direct telephone access to SSA's local field offices was terminated, so that the public can no longer call most of these offices directly.

Since October 1989, there have been many complaints from the public about SSA's telephone service. These complaints focus on high 800 number busy rates, on problems with the accuracy and completeness of information provided to callers, and on difficulties caused by the elimination of telephone access to local offices.

House bill

No provision.

Senate amendment (Sections 6055-6056 of Senate amendment)

The Secretary would be required to carry out demonstration projects testing a set of accountability procedures in at least three teleservice centers. These procedures are intended to assure that individuals who conduct business with the agency via telephone concerning title II, title XVI, or title XVIII benefits are not disadvantaged, either as a result of receiving incorrect information or from their inability to document their own actions and requests. Under these procedures, callers who provide adequate identifying information would be given a written confirmation of the date and nature of their telephone communication with the agency. This confirmation would include the name of the SSA employee with whom the caller spoke, a description of any action that the employee said would be taken in response to the call, and any advice that the caller was given. SSA would be required to maintain a copy of this confirmation for a minimum of five years following the termination of the demonstration projects.

Routine telephone communication would be excluded from these requirements. Thus, callers making inquiries that do not relate to potential or current entitlement or eligibility for title II, title XVI or title XVIII benefits—i.e., questions about the location or hours of operation of local offices—would not be subject to the accountability procedures described above.

The Secretary would be required to issue a report to the Committee on Ways and Means and the Committee on Finance on the demonstration projects. This report would:

- (i) Assess the costs and benefits of the accountability procedures;
- (ii) Identify any major difficulties encountered in implementing the demonstration projects; and
- (iii) Assess the feasibility of implementing the accountability procedures nationally.

The telephone demonstration projects would be required to be initiated within six months of the enactment of this Act, and would continue for one to three years. The report would be submitted 90 days after the termination of the projects.

Conference agreement

The conference agreement follows the Senate amendment.

8. NOTICE REQUIREMENTS

(Section 5109 of the Conference Agreement)

Present law

The Secretary must use understandable language in notifying individuals of a denial of disability benefits. The law is silent regarding the language of other notices.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, provides that, in issuing notices regarding title II and title XVI benefits, the Secretary would be required to:

- (i) Use clear and simple language;
- (ii) Include the local office telephone number and address in notices generated by SSA local offices;
- (iii) Include the address of the local office which serves the recipient of the notice and a telephone number through which that office can be reached in notices generated by SSA central offices.

The provision would apply to notices issued on or after January 1, 1991.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828, effective with respect to notices issued on or after July 1, 1991.

9. RESTORATION OF TELEPHONE ACCESS TO THE LOCAL OFFICES OF THE SOCIAL SECURITY ADMINISTRATION

(Section 5110 of the Conference Agreement)

Present law

The Social Security Act is silent regarding telephone service provided by the Social Security Administration (SSA). In practice, SSA currently operates 37 teleservice centers (TSCs) that respond to inquiries from the public. In addition to providing general program

information, these TSCs can schedule appointments at local offices and provide individual service, including discussing a person's eligibility and taking specific actions regarding his or her benefits. In October 1988, the TSCs were integrated into a toll-free telephone network that covered 60 percent of the population. In October 1989, toll-free service was extended via the TSCs and four new mega-TSCs to the entire country. At the same time, direct telephone access to SSA's local field offices was terminated, so that the public can no longer call most of these offices directly.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision that is similar to the Senate amendment, but requires restoration of SSA's local telephone service as soon as possible, but not later than 180 days following the date of enactment.)

Senate amendment (Section 6057 of Senate amendment)

The Senate amendment contains a provision that would require the Secretary to reestablish telephone access to local SSA offices at the level generally available on September 30, 1989 (the date just prior to the cut-off of direct telephone access to most local offices). The Secretary would also be required to re-list these local office numbers in local telephone directories (as well as in the directories used by public telephone operators in providing callers with information). The required telephone listings could include a brief instruction to the public to call SSA's 800 number for general information.

In addition, by January 1, 1993, the Secretary would be required to submit to the Committee on Finance and the Committee on Ways and Means a report which: (i) assesses the impact of the requirements established by this provision on SSA's allocation of resources, workload levels, and service to the public, and (ii) presents a plan for using new, innovative technologies to enhance access to the Social Security Administration, including access to local offices. If the Secretary's plan provides for maintaining or enhancing public access to local offices by individuals in need of assistance from a local SSA representative, it is the Conferees' intent to reconsider the need for a statutory requirement governing telephone access.

The provision would be effective April 1, 1991.

Not later than 90 days after enactment, the General Accounting Office would be required to report to the Committee on Finance and the Committee on Ways and Means on the level of public telephone access to the local offices of the Social Security Administration.

Conference agreement

The conference agreement generally follows the Senate amendment, but includes the effective date and GAO reporting deadlines contained in H.R. 5828.

10. IMPROVEMENT IN EARNINGS AND BENEFIT STATEMENTS

(Section 5111 of the Conference Agreement)

Present law

The Omnibus Budget Reconciliation Act of 1989 required the Social Security Administration to establish a program under which covered workers receive periodic statements concerning their earnings and the potential benefits payable on the basis of those earnings. Under that legislation, these statements are to be provided on a biennial basis starting October 1, 1999.

House bill

No provision.

Senate amendment (Section 6058 of Senate amendment)

The requirement that earnings and benefit statements be provided biennially starting in 1999 would be modified to require annual statements beginning at that time. In addition, the Secretary of the Treasury would be authorized to disclose to the Commissioner of Social Security the mailing address of any taxpayer who is entitled to receive an earnings and benefit statement.

The provision would be effective upon enactment.

Conference agreement

The conference agreement follows the Senate amendment.

11. PROVIDE A ROLLING FIVE-YEAR TRIAL WORK PERIOD FOR ALL
DISABLED BENEFICIARIES

(Section 5112 of the Conference Agreement)

Present law

Under present law, disability beneficiaries who are still disabled but who want to return to work despite their disabling condition are entitled to a nine-month trial work period. (The months need not be consecutive.) During this period, disabled beneficiaries may test their ability to work without affecting their entitlement to disability benefits. Any work and earnings are disregarded in determining whether the beneficiary's disability has ceased. At the end of this period, the beneficiary's work and earnings are evaluated to determine whether he is able to engage in Substantial Gainful Activity (SGA), which is currently defined by regulation as earnings of more than \$500 per month. If so, his benefits are terminated two months later.

Only one trial work period is allowed in any one period of disability. In addition, an individual who is entitled to disabled worker's benefits for which he has qualified without serving a waiting period (i.e., the worker was previously entitled to disabled worker's benefits within five years before the month he again becomes disabled) is not entitled to a trial work period.

House bill

No provision.

Senate amendment (Section 6059 of Senate amendment)

All beneficiaries would be given an opportunity to test their capacity to engage in substantial gainful activity over a sustained period of time before their benefits would be stopped by providing that a disabled beneficiary would exhaust his nine-month trial work period only if he performed services in any nine months within a rolling 60-month period (that is, within any period of 60 consecutive months) and repealing the provision which precludes a reentitled disabled worker from being eligible for a trial work period.

The provision would be effective January 1, 1992.

Conference agreement

The conference agreement follows the Senate amendment.

12. CONTINUATION OF BENEFITS ON ACCOUNT OF PARTICIPATION IN A
NON-STATE VOCATIONAL REHABILITATION PROGRAM

(Section 5113 of the Conference Agreement)

Present law

Social Security disability insurance (DI) benefits or Supplemental Security Income (SSI) benefits based on disability that are paid to a beneficiary who has medically recovered may not be terminated or suspended because the disability has ceased if: (1) the individual is participating in an approved State vocational rehabilitation program, and (2) the Commissioner of Social Security determines that completion of the program, or its continuation for a specified period of time, will increase the likelihood that the individual may be permanently removed from the benefit rolls. The 1988 Disability Advisory Council recommended that the same benefit continuation provisions be extended to beneficiaries who medically recover while participating in other approved vocational rehabilitation programs.

House bill

No provision.

Senate amendment (Section 6060 of Senate amendment)

The provision would extend to those DI or SSI beneficiaries who medically recover while participating in a non-State vocational rehabilitation program approved by the Secretary the same benefit continuation rights as those who medically recover while participating in a State vocational rehabilitation program.

The provision would be effective with respect to benefits payable for months after the eleventh month following the month of enactment and would apply with respect to individuals whose disability has or may have ceased after such eleventh month.

Conference agreement

The conference agreement follows the Senate amendment.

13. LIMITATION ON NEW ENTITLEMENT TO SPECIAL AGE-72 PAYMENTS

(Section 5114 of the Conference Agreement)

Present law

Special age-72 benefits (so-called "Prouty benefits" after Senator Winston Prouty of Vermont) were enacted in 1966 to provide some payment to individuals who, when the social security program began or when coverage was extended to their jobs, were too old to earn enough quarters of coverage to become fully insured for regular retirement benefits.

When the benefits were created in 1966, it was expected that new entitlement under this provision would not be possible for anyone reaching age 72 after 1971. This is because individuals age 72 after 1971 who met the quarters-of-coverage requirements for Prouty benefits would also have enough quarters of coverage to be fully insured and thus eligible for the minimum benefit. Because the amount of the Prouty benefits was less than the amount of the minimum benefit payable at age 62, new entitlement to Prouty benefits would not occur. However, due to subsequent changes in the law, it is now theoretically possible for certain people who will reach age 72 after 1990 and who receive the frozen minimum benefit (due to a change in the law in 1977) or who receive less than the minimum benefit (due to its elimination in 1982) to become newly eligible for Prouty benefits. In 1990, the Prouty benefit amount is \$159 per month.

House bill

No provision.

Senate amendment (Section 6061 of Senate amendment)

The provision would preclude the unintended payment of Prouty benefits (due to the interaction of the Prouty benefit provision with subsequent changes in the law affecting the minimum benefit) by providing that Prouty benefits would not be payable to any individual reaching age 72 after 1971. This change would not affect any current Prouty beneficiaries.

The provision would be effective upon enactment.

Conference agreement

The conference agreement follows the Senate amendment.

14. ELIMINATION OF ADVANCE TAX TRANSFER

(Section 5115 of the Conference Agreement)

Present law

Because of the threatened insolvency of the social security trust funds, the Social Security Amendments of 1983 changed the rules for crediting the trust funds with social security tax receipts. Prior to 1983, the trust funds were credited with the receipts as they were collected throughout each month. Under the 1983 amendments, the trust funds are credited at the start of each month with the full amount of social security tax receipts which are expected

to be collected throughout the month. These receipts are invested in interest bearing Treasury securities; however, an interest adjustment is made later to leave the trust funds with the same interest earnings that they would have had if the taxes had been credited on an "as received basis." The present crediting rules may present Treasury with a situation in which trust fund assets cannot be invested when the debt limit has been reached.

House bill

No provision.

Senate amendment (Section 6062 of Senate amendment)

The advance tax transfer provisions would be repealed, returning to the prior procedure of crediting the trust funds as tax receipts are received. However, the advanced tax transfer mechanism would be retained as a contingency to be exercised only to the extent that the Secretary of the Treasury determines is necessary to assure sufficient funds to meet current benefit obligations. This would give the social security program the same level of protection that it enjoys under present law without continuing the routine use of the advance transfer mechanism.

The provision would be effective after December 1990.

Conference agreement

The conference agreement follows the Senate amendment, effective the first day of the month following the month of enactment.

15. REPEAL OF RETROACTIVE BENEFITS FOR CERTAIN CATEGORIES OF INDIVIDUALS

(Section 5116 of the Conference Agreement)

Present law

Social security retirement and survivor benefits can be paid for up to six months prior to the month of application if the applicant were otherwise eligible for benefits during that period.

In general, retroactive benefits cannot be paid if doing so would cause a reduction in future monthly benefits (i.e., it would effectively mean that an individual would be filing for "early retirement," in which case an actuarial reduction in benefits is required). For example, if a retroactive application for retirement benefits were to cause a retiree's initial entitlement month to fall before the individual reached age 65, no retroactive benefits could be paid for the months prior to age 65. However, there are four exceptions to this rule which permit payment of retroactive benefits even though it causes an actuarial reduction in benefits.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6063 of Senate amendment)

The provision would eliminate eligibility for retroactive benefits for two categories of individuals eligible for actuarially reduced benefits: (1) individuals who have dependents who would be entitled to unreduced benefits during the retroactive period (e.g., a retiree under age 65 who has a spouse age 65 or over); and (2) individuals who have pre-retirement earnings over the amount allowed under the social security retirement test that could be charged off against benefits for months prior to the month of application, thus permitting an early retiree to receive benefits for months prior to actual retirement.

The provision would be effective with respect to applications for benefits filed on or after January 1, 1991.

Conference agreement

The conference agreement follows the Senate amendment.

16. CONSOLIDATION OF OLD COMPUTATION METHODS

(Section 5117 of the Conference Agreement)

Present law

A number of old, rarely-used benefit computation methods remain in the Social Security Act. They apply primarily to claims in which the worker filed for benefits or died before 1967 and are used only if they provide a higher benefit than newer computation methods.

Such computations must be done manually. The Social Security Administration (SSA) estimates it would be costly to develop computer programs for these rarely-used benefit computation methods.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6064 of Senate amendment)

The provision would eliminate all old computation methods which require manual intervention. It would substitute newer computation methods which may be fully processed by computer.

The provision would apply only to new claims for benefits, virtually all of which are for survivor's benefits, and to recomputations for certain retired workers now on the rolls who have recent earnings. However, it is unlikely that there are many individuals who are over 85 and are working at a wage high enough to result in an increase in benefits after a recomputation using a computation method to be eliminated under this provision. No benefits paid to individuals already on the rolls would be reduced.

The provision would be effective 18 months after the month of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

17. SUSPENSION OF DEPENDENT'S BENEFITS WHEN A DISABLED WORKER IS IN AN EXTENDED PERIOD OF ELIGIBILITY

(Section 5118 of the Conference Agreement)

Present law

A disability insurance beneficiary who successfully completes a nine-month trial work period has an extended period of eligibility during which he or she continues to receive medicare benefits and is eligible to receive disability benefits if earnings fall below \$500 a month. The law is silent regarding the payment of benefits to dependents during this extended period. However, current Social Security Administration (SSA) policy provides that dependent's benefits are suspended during this period if the disabled worker's benefits are suspended.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment (Section 6065 of Senate amendment)

The Senate amendment contains a provision that would codify current SSA policy which links the disabled worker's entitlement to monthly benefits and the dependent's entitlement to benefits for the same month. Thus, a dependent could receive benefits for a month only if the disabled worker received benefits for that month.

The proposal would be effective upon enactment.

Conference agreement

The conference agreement follows the Senate amendment.

18. PAYMENT OF BENEFITS TO DEEMED SPOUSE AND LEGAL SPOUSE

(Section 5119 of the Conference Agreement)

Present law

A spouse or widow(er) whose marriage is found to be invalid (i.e., the husband or wife failed to obtain a legal divorce from a previous spouse, or there was some defect in the marriage ceremony) is eligible for benefits as a "deemed" spouse or widow(er) if he or she is living with the worker (or was at the time of the worker's death) and there is no legal spouse who is currently entitled or had previously been entitled to benefits on the worker's record. In cases where a deemed spouse is paid benefits and a legal spouse later files for benefits, the deemed spouse's benefits are terminated when the legal spouse becomes entitled. The deemed spouse may again receive benefits if the legal spouse and the worker legally divorce, or if the legal spouse dies.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision that would pay benefits to both the legal spouse and the deemed spouse (or to both the legal widow

and the deemed widow). That is, the existence of a legal spouse would no longer prevent a deemed spouse from receiving benefits on the worker's record or terminate the benefits of a deemed spouse who was already receiving benefits on the worker's record.

A deemed spouse or deemed widow(er) would be entitled to benefits on the worker's record on the same basis as if he or she were a legal spouse and would be paid within the family maximum. The legal spouse would also be entitled to benefits and would be paid outside the family maximum once the deemed spouse became entitled to benefits.

In order to qualify as a deemed spouse, the individual would be required to be living with the worker at the time of filing for benefits (or at the time of the worker's death, in the case of deemed widow(er)'s benefits). A deemed spouse who divorced the worker would be eligible for benefits on the same basis as if he or she were a divorced legal spouse.

The provision would be effective with respect to benefits payable for months after December 1990. With respect to deemed spouses or deemed widow(er)'s whose benefits have been terminated prior to December 1990, the provision would be effective for applications filed on or after January 1, 1991.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

19. VOCATIONAL REHABILITATION DEMONSTRATION PROJECT

(Section 5120 of the Conference Agreement)

Present law

Since the establishment of the Disability Insurance (DI) cash benefits program in 1956, the Social Security Administration (SSA) has been required to refer disabled beneficiaries and applicants to State vocational rehabilitation agencies so that the maximum number of them may be rehabilitated and return to work. When the services provided by a State agency result in a beneficiary engaging in substantial gainful activity for at least nine months, SSA reimburses the agency for the cost of these services from the DI trust fund (or, in the case of disabled widow(er)s and disabled adult children, from the OASI trust fund).

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, requires SSA to develop and carry out demonstration projects assessing the advantages and disadvantages of permitting disabled beneficiaries to select a qualified rehabilitation agency, public or private, to provide them with services aimed at enabling them to engage in substantial gainful activity and leave the disability rolls. Those eligible to participate in the demonstration projects would include disability insurance beneficiaries, disabled

widow(er)s, and disabled adult children. The project would be implemented in at least three sites in three separate states. They would include a sufficient number of beneficiaries and be of sufficient scope to permit an evaluation of:

The extent to which disabled beneficiaries will participate in the provider selection process (including an identification of their reasons for participating or not participating);

The characteristics (including impairments) of beneficiaries by the type of provider selected;

The rehabilitation needs of beneficiaries by the type of provider selected;

The extent to which non-State vocational rehabilitation firms accept referrals of disabled beneficiaries on the basis of current law reimbursement provisions and of the most effective mechanisms for reimbursing such providers within the framework of current law;

The extent to which providers participating in the demonstration projects contract out services and the types of services that are contracted out;

Whether beneficiaries who select their own vocational rehabilitation provider are more likely to work and leave the disability rolls than those who do not;

The cost effectiveness of permitting beneficiaries to select their vocational rehabilitation provider and of different types of providers; and

The feasibility of enacting the arrangement being tested on a national basis and the additional procedural safeguards, if any, needed to assure its effectiveness if made part of permanent law.

In selecting beneficiaries to participate in the project, the Secretary must choose those for whom there is a reasonable likelihood that the rehabilitation services provided will result in their performance of substantial gainful activity for a continuous period of nine months prior to the completion of the project.

Project participants would be permitted to select a qualified provider to furnish them with rehabilitation services. After seeking recommendations from disabled individuals and organizations representing them, the Secretary would designate a number of qualified providers in the geographic areas of each of the three demonstration sites. In addition, the Secretary would have authority to approve rehabilitation services provided outside these areas on a case-by-case basis.

Providers that participate in the project would be reimbursed in accordance with current law (section 222(d) of the Social Security Act), except that the Secretary would be permitted to contract with qualified providers on a fee-for-service basis to: (1) conduct vocational evaluations aimed at identifying those participants who have a reasonable potential for engaging in substantial gainful activity and being removed from the disability rolls if provided with vocational rehabilitation services; and (2) develop jointly with those participants an individualized written rehabilitation program.

This program would include, but not be limited to: (1) a statement of the individual's rehabilitation goal; (2) a statement of the specific rehabilitation services to be provided and the rehabilitation

provider from which those services will be obtained; (3) the projected date for the initiation of such services and their anticipated duration; and (4) objective criteria and an evaluation procedure and schedule for determining whether the goals are being achieved.

The demonstration project would run for three years. By April 1, 1992, the Secretary would be required to submit a report on the progress of the projects to the Committee on Ways and Means and the Committee on Finance. A final report to these Committees would be due six months after completion of the projects, or by April 1, 1994.

Authority for this demonstration project is provided as an amendment to section 505 of the Social Security Disability Amendments of 1980. To allow for completion of these projects, the Secretary's general authority under section 505 would be extended by approximately three months, from June 10, 1993, to October 1, 1993.

The provision would be effective upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

20. USE OF SOCIAL SECURITY NUMBER BY CERTAIN LEGALIZED ALIENS

(Section 5121 of the Conference Agreement)

Present law

The use of a false social security number or social security card or the misreporting of social security covered earnings, with intent to deceive, is a felony under section 208 of the Social Security Act, punishable by a maximum penalty of up to \$250,000 or up to 5 years imprisonment. The Immigration Reform and Control Act of 1986 (IRCA) extended amnesty and the opportunity to obtain legal status to certain illegal aliens who had been resident and working in the United States for a substantial period of time. However, persons legalized under IRCA are still subject to prosecution for use of a false social security number or card under section 208 of the Social Security Act. As a result, alien workers who are granted temporary or permanent legal resident status under IRCA, and who apply for a correct social security number or attempt to correct their earnings records with the Social Security Administration, may be subject to prosecution as a result of their previous use of a false number or card.

House bill

No provision. (H.R. 2858 includes a provision that would amend the Social Security Act to provide that aliens who, under IRCA or section 902 of the Foreign Relations Authorization Act for Fiscal Years 1988 and 1989, applied for and were granted legal status would not be prosecuted under certain of the criminal provisions in section 208, by virtue of having used a false social security number

or card or having misreported earnings with intent to deceive, during the period prior to, or within 60 days after enactment of this provision. The exemption would not apply to those who sold social security cards, possessed social security cards with intent to sell, possessed counterfeit social security cards with intent to sell or counterfeited social security cards with intent to sell.

The purpose of IRCA is to give most illegal aliens who had been long established in the United States (generally present since January 1, 1982) and who are contributing members of the society an opportunity to become legal residents and lead normal lives. The use of false social security numbers was a common practice among illegal aliens attempting to work in the United States.

When this population was given amnesty from prosecution for violation of the immigration laws, the fact that they could still be prosecuted for previously using a false social security number or card, even after obtaining temporary or permanent resident status, was not addressed. As a result, most of the legalized population is still technically subject to prosecution and loss of legal status as soon as they attempt to correct their earnings records. Many aliens who have applied for, or have been granted, amnesty have not yet corrected their social security earnings record for fear of prosecution under section 208.

The Conferees intend that this exemption apply only to those individuals who use a false social security number to engage in otherwise lawful conduct. For example, an alien who used a false social security number in order to obtain employment which results in eligibility for social security benefits or the receipt of wage credits would be considered exempt from prosecution. However, an alien who used a false social security number for otherwise illegal activity such as bank fraud or drug trafficking would not be exempt from prosecution under this provision.

The provision would make the Social Security Act consistent with the amnesty provisions of IRCA. The Conferees believe that individuals who are provided exemption from prosecution under this proposal should not be considered to have exhibited moral turpitude with respect to the exempted acts for purposes of determinations made by the Immigration and Naturalization Service.

The exemption would apply to all individuals who received amnesty regardless of when they were granted status.

The provision would be effective for fraudulent use which occurred prior to, or within 60 days after, enactment by any person who is ultimately granted legal status under IRCA or section 902 of the Foreign Relations Authorization Act for fiscal years 1988 and 1989.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828 with minor changes.

21. REDUCTION IN WAGES NEEDED FOR A YEAR OF COVERAGE TOWARD THE SPECIAL MINIMUM BENEFIT

(Section 5122 of the Conference Agreement)

Present law

A "special minimum" social security benefit is available to workers who have many years of work at modest wages. The amount of this benefit is determined by an alternative benefit computation that calculates the benefit based on the number of years of significant earnings, rather than on average lifetime earnings. It applies in cases where this computation results in a higher benefit than that which would be derived under the regular social security benefit computation rules.

The special minimum benefit is computed by multiplying the number of years of special minimum coverage by a base amount. However, only those years in excess of 10 and up to 30 can be multiplied by the base amount (e.g., if an individual has 30 years of coverage toward the special minimum, only 20 of these years can be multiplied by the base amount to determine the benefit amount). In 1990, the base amount is \$21.90. A worker with 30 years of coverage under the special minimum would receive a benefit of \$437.

For 1951-1978, the individual earns a year of coverage for each year in which he or she has wages or self-employment income of at least 25 percent of the social security contribution and benefit base for that year and, for years after 1978, at least 25 percent of the old-law contribution and benefit base for that year.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision that would reduce the amount of wages or self-employment income required to earn a year of coverage from 25 percent of the old-law contribution and benefit base (projected by the Congressional Budget Office to be \$10,125 in 1991) to 15 percent of the old-law contribution and benefit base (projected to be \$6,075 in 1991).

Because the minimum wage was not increased from 1981 through 1989, while the social security contribution and benefit base has been indexed to wage increases, the level of wages required to earn a year of coverage under the special minimum benefit provision has exceeded the minimum wage in every year since 1983. The provision would make it possible once again for a minimum-wage earner to earn years of coverage toward the special minimum. (In 1991, a full-time minimum wage worker would earn \$8,606.)

The provision would be effective for years of coverage earned after 1990.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

22. CHARGING OF EARNINGS OF CORPORATE DIRECTORS

(Section 5123 of the Conference Agreement)

Present law

The Omnibus Budget Reconciliation Act of 1987 required that, for purposes of both social security taxation and the retirement test, corporate directors' earnings be treated as received in the year that the services to which they are attributable were performed. Prior to OBRA, because corporate directors' earnings were taxed when received, directors were able to avoid benefit reductions from the retirement test by deferring receipt of earnings until reaching age 70.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, would repeal the provision that treats directors' earnings as taxable in the year that the services to which they are attributable were performed. Thus, directors' earnings would be treated as received in the year that the relevant services are performed only for purposes of the social security retirement test.

The provision would be effective with respect to services performed in taxable years beginning after December 31, 1990.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828 with technical drafting changes.

23. COLLECTION OF EMPLOYEE SOCIAL SECURITY TAX ON GROUP-TERM LIFE INSURANCE

(Section 5124 of the Conference Agreement)

Present law

The Omnibus Budget Reconciliation Act of 1987 required the cost of employer-provided group-term life insurance to be included in wages for FICA tax purposes if it is includible for income tax purposes. Under current law, it is includible for income tax purposes to the extent that coverage exceeds \$50,000.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, provides that in cases where an employer continues to provide taxable group-term life insurance to an individual who has left his employment, the former employee would be required to pay the employee portion of the FICA tax directly. To enable him to do this, the employer would be required to list separately on the

former employee's W-2 each year the amount of the payment for group-term life insurance and the amount of the employee FICA tax imposed on it. Instructions on form 1040 would then direct the employee to add this amount to his total tax liability. This procedure follows an existing procedure by which employees with income from tips pay the employee share of the FICA tax directly when their wages are not sufficient to enable their employer to withhold it.

A conforming change would be made in the Railroad Retirement Tax Act.

The proposal would apply to group-term life insurance coverage provided after December 31, 1990.)

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

24. CROSS-REFERENCING OF RAILROAD RETIREMENT TIER 1 TAX RATE TO THE FEDERAL INSURANCE CONTRIBUTIONS ACT

(Section 5125 of the Conference Agreement)

Present law

The railroad retirement Tier 1 tax rate is equivalent to the combined OASDI and HI tax rates of the Federal Insurance Contributions Act (FICA). The Tier 1 rate is described numerically in the Railroad Retirement Tax Act.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision identical to the Senate amendment.)

Senate amendment

The Senate amendment would amend the Railroad Retirement Tax Act to provide that the Tier 1 tax rate would be determined by cross-reference to the FICA tax rate.

The provision would be effective upon enactment.

Conference agreement

The conference agreement follows the Senate amendment.

25. TWO-YEAR EXTENSION OF GENERAL FUND TRANSFER TO RAILROAD RETIREMENT TIER 2 FUND

(Section 5126 of the Conference Agreement)

Present law

The proceeds from the income taxation of railroad retirement Tier 2 benefits are transferred from the general fund of the Treasury in the Railroad Retirement Account. This transfer applies only to proceeds from the taxation of benefits which have been received

prior to October 1, 1990. Proceeds from the taxation of benefits received after this date will remain in the general fund.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision similar to the Senate amendment but providing for a two-year rather than a one-year extension of the transfer provision.)

Senate amendment

The Senate amendment would provide for extending the transfer of proceeds from the income taxation of Tier 2 benefits for an additional year, that is, with respect to benefits received prior to October 1, 1991. The continuation of this transfer is estimated to result in an additional deposit into the Railroad Retirement Account of \$190 million.

The provision would be effective with respect to benefits received after September 30, 1990 and before October 1, 1991.

Conference agreement

The conference agreement follows the Senate amendment with a modification under which the transfer would be extended for two years rather than one. This two-year extension is estimated to result in an additional deposit into the Railroad Retirement Account of \$385 million.

The provision would be effective with respect to benefits received after September 30, 1990 and before October 1, 1992.

26. WAIVER OF THE TWO-YEAR WAITING PERIOD FOR CERTAIN DIVORCED SPOUSES

(Section 5127 of the Conference Agreement)

Present law

A divorced spouse is entitled to benefits on the record of a worker to whom he or she was previously married so long as three conditions are met: 1) both the worker and the divorced spouse are eligible for social security retirement benefits (i.e., are age 62 or older); 2) the marriage lasted 10 years; and 3) the worker is receiving benefits.

If the worker is eligible for benefits but is not receiving them (because the worker has not filed for benefits or because benefits have been suspended due to the retirement test), the divorced spouse may nevertheless be paid benefits on the worker's record, but only when the divorce has been final for two years. The purpose of this two-year waiting period is to prevent couples from obtaining a divorce solely to avoid suspension of spousal benefits under the retirement test. The waiting period is imposed on any divorced spouse whose former spouse does not receive benefits, regardless of whether the divorced spouse was receiving benefits prior to the divorce. Some people argue that the waiting period imposes a hardship on a spouse who had been receiving benefits prior to the divorce, but who loses these benefits because the former spouse returned to work after the divorce.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision that would waive the two-year waiting period for independent entitlement to divorced spouse's benefits if the worker was entitled to benefits prior to the divorce. In this way, a spouse whose divorce took place after the couple had begun to receive retirement benefits, and whose former spouse (the worker) returned to work after the divorce thus causing the suspension of benefits, would not lose benefits on which he or she had come to depend.

The provision would be effective for benefits payable for months after December, 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

27. PREEFFECTUATION REVIEW OF FAVORABLE DECISIONS BY THE SOCIAL SECURITY ADMINISTRATION

(Section 5128 of the Conference Agreement)

Present law

The Social Security Disability Amendments of 1980 require the Secretary of Health and Human Services (HHS) to review 65 percent of favorable title II decisions made by State Disability Determination Services (DDSs) each year prior to their effectuation. The review applies to favorable decisions on initial claims, on reconsiderations, and on continuing disability reviews. At Social Security Administration's (SSA's) current volume of applications and appeals, the agency is required to conduct about 450,000 preeffectuation reviews annually.

The Committee on Ways and Means approved the 65 percent requirement in 1980 as a means of promoting uniformity and accuracy in favorable disability decisions. At that time, the Committee noted that: "... in some instances reviewing this percentage of cases may not be cost effective—a lower or higher percentage may be prudent. If the Secretary finds this to be the case, we would expect him to report his findings to [the] Committee in an expeditious manner." (H. Rept. 96-100, p. 10)

Since 1981, SSA improved its capacity to identify the general types of approvals and continuances that are most likely to be incorrect. These improvements were documented in a March 1990 report by the General Accounting Office, which suggests that SSA can maintain current levels of accuracy, and possibly even improve upon them, by targeting preeffectuation reviews on error-prone cases.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, would reduce the percentage of favorable state agency

decisions that the Secretary must review from 65 percent across-the-board to 50 percent of allowances. The 50 percent requirement would apply to both initial allowances and allowances upon reconsideration. The Secretary would also be required to review a sufficient number of continuances to assure a high level of accuracy in such decisions. To the extent feasible, the reviews would focus on allowances and continuances that are likely to be incorrect.

SSA would be required to submit annual written reports to the Committee on Ways and Means and the Committee on Finance which (i) state the number of preeffectuation reviews conducted the previous year and, (ii) based on these reviews, assess the accuracy of DDS decisions.

The provision would apply to reviews of state agency determinations made after fiscal year 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the provision contained in H.R. 5828.

28. INCREASE IN THE RETIREMENT TEST FOR WORKERS AGE 65-69

Present law

In 1990, individuals age 65-69 may earn up to \$9,360 in annual wages or self-employment income and still be treated as retired; that is, they will have no reduction in their social security benefit as a result of earnings at or below this exempt amount. The exempt amount is automatically adjusted each year to reflect the change in average wages in the economy. The retirement test for those age 65-69 will rise to \$9,720 in 1991 and is projected by the Congressional Budget Office to be \$10,560 in 1992, \$11,160 in 1993, \$11,760 in 1994, and \$12,480 in 1995. The retirement test for those under age 65 is currently \$6,840 and will rise to \$7,080 in 1991.

For earnings in excess of these amounts, beneficiaries age 65-69 lose \$1 in benefits for every \$3 in earnings. Beneficiaries under age 65 lose \$1 in benefits for every \$2 in earnings in excess of the limit. Persons age 70 years and older are not subject to the retirement test.

House bill

No provision. (H.R. 5828, as reported by the Committee on Ways and Means, includes a provision that would increase the retirement test applied to those age 65-69 by \$1,800 in 1993 and \$2,640 in 1994 above the level which would occur under the automatic procedure. The resulting exempt amount is projected to be \$12,960 in 1993 and \$14,400 in 1994. These ad hoc increases would be included permanently in the exempt amount so that automatic increases in future years would be calculated based on an inclusion of these ad hoc increases.

The provision would be effective for taxable years ending after 1990.)

Senate amendment

No provision.

Conference agreement

The conference agreement follows the Senate amendment, i.e., no provision.

29. ELIMINATION OF BENEFIT RECOMPUTATIONS FOR EARNINGS AFTER
AGE 69

Present law

The amount of a worker's monthly social security retirement benefit is established at age 62. It is based on an average of the worker's lifetime earnings, using the 35 years with the highest earnings to compute the average. (For workers reaching age 62 in 1989 or earlier, fewer years are used in computing average lifetime earnings.) Earnings from years prior to the year the worker reached age 61 are indexed to reflect wage growth. A worker who does not have 35 years of earnings has a zero averaged into his or her average lifetime earnings for each year in which he or she had no wages or self-employment income.

If a worker continues to have earnings after age 61, and these earnings are higher than indexed earnings in one of the 35 years used to compute average lifetime earnings, the higher-earning year is substituted for a lower-earning year or a year with no earnings. This raises the worker's average lifetime earnings and the monthly benefit is recomputed to produce a higher benefit amount.

House bill

No provision. (H.R. 5828 includes a provision that would eliminate recomputations of benefits for beneficiaries with earnings in the year they reach age 70 or later years, except for beneficiaries with one or more "zero years" averaged into their average lifetime earnings.

The provision would be effective for recomputations of benefits on the basis of wages or self-employment income for years after 1990.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the Senate amendment, i.e., no provision.

30. RECOVERY OF OVERPAYMENTS FROM FORMER SOCIAL SECURITY
BENEFICIARIES THROUGH TAX REFUND OFFSET

(Section 5129 of the Conference Agreement)

Present law

A Federal agency that is owed a past-due, legally enforceable debt, other than a title II overpayment, can collect it by having the Internal Revenue Service (IRS) withhold or reduce the debtor's

income tax refund. To obtain repayment via a tax refund offset, the agency to which the debt is owed must:

- (i) Notify the individual of its intention to recover the debt through the tax system;
- (ii) Provide the individual with at least 60 days to present evidence that all or part of the debt is not past-due or not legally enforceable; and
- (iii) Consider any evidence presented by the individual and make a final determination that the debt is in fact owed and legally enforceable.

After the agency notifies the IRS of its final determination, the IRS reduces the amount of the individual's income tax refund, if any; pays this amount to the agency; and notifies the individual of the amount by which his tax refund has been reduced to repay his debt.

House bill

Social security overpayments to former beneficiaries would be recovered by withholding the amount due from Federal income tax refunds. This recovery method would be used only when benefit adjustments or direct payments by the overpaid individual have not been successful.

Specifically, the prohibition against recovering title II overpayments via a tax refund offset would be eliminated for former beneficiaries. (Current beneficiaries would continue to be exempt from the tax refund offset program.)

After being informed by the Social Security Administration (SSA) of its intention to recover an overpayment via a tax refund offset, former beneficiaries who are eligible to apply for a waiver of the overpayment would be given the opportunity to do so. In addition, the IRS would be required to establish a procedure by which a spouse could prevent his or her share of a joint tax refund from being withheld in an overpayment recovery action. The IRS would also be required to notify individuals who file joint returns of this procedure when it informs them that it is withholding their tax refund.

The proposal would take effect January 1, 1991, and would remain in effect as long as the existing Government-wide offset remains in effect (currently, until January 10, 1994).

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

31. TECHNICAL AMENDMENTS

(Section 5130 of the Conference Agreement)

The provision would correct several technical errors contained in the Social Security Act.

CHILD CARE STATEMENT OF MANAGERS

The Conference report includes the Child Care and Development Block Grant Act of 1990. The purpose of this block grant program is to increase the availability, affordability, and quality of child care. The provision provides financial assistance to low-income, working families to help them find and afford quality child care services for their children. It also contains provisions to enhance the quality and increase the supply of child care available to all parents, including those who receive no financial assistance under the block grant program.

More specifically, the purpose of this block grant program is to give parents a variety of options in addressing family child care needs. Additionally, this provision is intended to build on and to strengthen the role of the family by seeking to ensure that parents are not forced by the lack of available programs or financial resources to place a child in an unsafe or unhealthy child care arrangement; to promote the availability and diversity of quality child care services to expand child care options available to all families who need such services; to provide assistance to families whose financial resources are not sufficient to enable such families to pay the full cost of necessary child care; to improve the productivity of parents in the labor force by lessening the stresses related to the absence of adequate child care services; and to provide assistance to states and Indian tribes to improve the quality of, and coordination among, child care programs and early childhood development programs.

The Conference agreement authorizes \$750,000,000 for fiscal year 1991, \$825,000,000 for fiscal year 1992, \$925,000,000 for fiscal year 1993, and such sums as may be necessary for fiscal years 1994 and 1995. Block grant funds are provided to states in accordance with a formula based on numbers of young children and of school lunch recipients.

Use of block grant funds for child care services

Each state shall use 75 percent of block grant funds for direct assistance to parents for child care services and to increase the supply and to improve the quality of child care. Block grant funds may only be used by the states for child care services and for activities which directly improve the availability and quality of care for families assisted under the Act. Quality activities eligible for funds under section 658E(c)(3)(B)(ii) should be the same type of quality activities specified in the quality reservation in section 658G. It is the conferees' intent that a preponderance of the block grant funds be spent specifically on child care services and a minimum amount on other authorized activities.

The managers believe that parents should have the greatest choice possible in selecting child care for their children. Thus, parents assisted under section 658E(c)(3)(B) would have complete discretion to choose from a wide range of child care arrangements, including care by relatives, churches, synagogues, family providers, centers, schools, and employers. All such providers may be paid through grants or contracts or through certificates provided to the

parent. A parent assisted under section 658E(c)(3)(B) must be given the option of receiving a certificate.

Use of 25 percent reserve of funds

Each state shall reserve 25 percent of block grant funds for grants and contracts to providers of early childhood development or before- and after-school services, or both, and for activities to improve the quality of child care. Of the 25 percent reserve, not less than seventy-five percent of this reserve shall be allocated to early childhood development and before- and after-school care activities; not less than twenty percent for quality activities, with the remaining five percent to be used for either purpose. A state may assign responsibility for the administration of early childhood development and latchkey programs to an agency other than the lead agency, such as an agency that has experience in the administration of existing education or preschool programs. Eligible quality activities include establishing or expanding resource and referral programs; making grants or loans to providers to assist them in meeting state and local child care standards; improving the monitoring of compliance with, and enforcement of, state standards and licensing and regulatory requirements; providing training and technical assistance; and improving salaries and other compensation paid to child care staff.

General provisions

Families eligible for assistance for child care are those who earn less than 75 percent of the state median income and who have children under age 13. The amount of assistance would be based on a sliding fee scale established by the state. Nothing in this subchapter is intended to prohibit the provision of services at no cost to families whose income is at or below the poverty level. Providers would receive payment at rates which would ensure equal access to services comparable to those provided to children whose care is not publicly subsidized.

Parental choice and involvement are further enhanced through provisions for unlimited parental access to children during the day and within the care setting, for parental complaint procedures and access to records of substantiated parental complaints, and for consumer education.

The managers intend that the determination whether any financial assistance provided under this subchapter, including a loan, grant or child care certificate, constitutes Federal financial assistance for purposes of title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681, et seq.), the Rehabilitation Act of 1973 (29 U.S.C. 794 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), all as amended, and the regulations issued thereunder, shall be made in accordance with those provisions.

To receive funds, a state shall submit a plan that includes: designation of a lead agency; local consultation regarding development of the plan; coordination with existing programs; use of funds for child care services, including early childhood education and before-and-after school care, and for activities related to quality and availability; supplement not supplant language; priority for very low

income children and children with special needs; and use of a sliding fee scale. The managers intend that, to the maximum extent practicable, the lead agency be a state entity in existence on or before the date of enactment of this subchapter with experience in the administration of appropriate child care programs.

All eligible providers shall be licensed, regulated, or registered prior to payment and must comply with applicable state and local licensing and regulatory requirements. The state plan shall describe minimum health and safety requirements established by the state for all providers funded under this subchapter and ensure that such providers demonstrate compliance with these requirements. These health and safety requirements include the prevention and control of infectious diseases, building and physical premises safety, and a minimum health and safety training requirement appropriate to the provider setting. The state shall conduct a one-time review of state licensing and regulatory requirements and policies, unless the state has done so within three years prior to the date of enactment.

The state shall report to the Secretary of Health and Human Services annually on the use of funds under this subchapter; data on caregivers and children in care; activities to encourage public-private partnerships which promote business involvement in meeting child care needs; results of any review of state licensing and regulatory requirements; a rationale for any state actions to reduce the levels of state standards; state actions to improve the quality of care; and a description of standards in the state.

The Secretary will report to Congress annually on use of all Child Care and Development Block Grant Act funds in the states. The report will include a summary and analysis of the above data provided by the States to the Secretary and any recommendations to Congress on further steps necessary to improve access to quality and affordable child care.

TITLE VI—ENERGY AND ENVIRONMENTAL PROGRAMS

SUBTITLE —NRC USER FEES

SEC. NRC USER FEES AND ANNUAL CHARGES

Present law

Section 7601 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) requires the Nuclear Regulatory Commission (NRC) to collect annual charges from its licensees. The amount of the charges:

- (1) when added to other amounts collected by the NRC (i.e., fees under the Independent Offices Appropriation Act of 1952, 31 U.S.C. 9701), may not exceed 33 percent of the NRC's costs; and
- (2) must reasonably be related to the regulatory service provided by the NRC and fairly reflect the cost to the NRC of providing the service.

Section 5601 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) amended the 1985 law by increasing the

(a) who was discharged or released from active military, naval, or air service for a disability incurred in the line of duty; or

(b) who was a veteran of any war; or

(c) by reference to section 902—

(1) who at the time of death was in receipt of either VA service-connected disability compensation (or but for the receipt of military retirement pay would have been entitled to compensation) or VA needs-based pension; or

(2) who either was a veteran of any war or was discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, whose body is held by a State (or a political subdivision of a State), and with respect to whom the Secretary determines (A) that there is no next of kin or other person claiming the body of the deceased veteran and (B) that there are not available sufficient resources to cover burial and funeral expenses.

Under section 903(b)(1), if an eligible veteran is buried (without charge for the cost of a plot or interment) in a State veterans cemetery which has similar criteria for burial as a national cemetery, VA pays the \$150 plot allowance directly to the State.

House bill

Section 11042 would eliminate the plot allowance for those whose eligibility is based solely on the status of veteran of any war (as described in item (b), above), but not those war veterans with eligibility through the reference to section 902 based on their not having sufficient resources to cover burial and funeral expenses and having no one claiming their remains. The plot allowance would continue to be payable for all veterans who meet current eligibility standards and are buried in State veterans cemeteries, and to all veterans discharged from service due to line-of-duty disabilities. The change would take effect with respect to deaths occurring on or after November 1, 1990.

Senate amendment

Section 11041 is substantively identical to the House provision.

Conference agreement

Section 8042 contains this provision.

According to CBO, the enactment of section 8042 would result in savings of \$27 million in outlays in FY 1991 and total savings of \$147 million in outlays in FYs 1991-1995.

SUBTITLE F—MISCELLANEOUS

Use of Internal Revenue Service and Social Security Administration data for income verification

Current law

Section 6103(l)(7) of the Internal Revenue Code of 1986 (26 U.S.C. 6103(l)(7)) authorizes disclosure by the Internal Revenue Service of certain third-party and self-employment tax information (from the Commissioner of Social Security or the Secretary of the Treasury) to certain Federal, State, and local entities administering certain

programs under the Social Security Act (essentially Supplemental Security Income, Aid to Families with Dependent Children, and Medicaid), the Food Stamp Act of 1977, or the unemployment compensation program for purposes of income verification, but does not authorize such access to VA for verifying the eligibility of recipients of needs-based, veterans' benefits.

House bill

Section 11051 would amend paragraph (7) of section 6103(l) of the Internal Revenue Code of 1986 so as to require disclosure to VA of (a) such third-party and self-employment tax information for purposes of determining eligibility for VA needs-based pension and parents' dependency and indemnity compensation and VA health-care services based on income status, and (b) only wage and self-employment information from such returns for purposes of determining eligibility for compensation paid (pursuant to section 4.16 of title 38, Code of Federal Regulations) at the total-disability-rating level based on an individual determination of unemployability.

To the extent that VA's general operating expenses (GOE) account appropriations are insufficient to fund administrative costs to implement the program, the Secretary would be required to pay the expenses from amounts available to the Department for the payment of compensation and pension.

This provision would expire on September 30, 1992.

Senate amendment

Section 11051 is substantively identical to the House bill except that (a) the requirement to pay implementation expenses from amounts available for the payment of VA compensation and pension would not be contingent on the insufficiency of GOE funds, and (b) there would be no expiration date.

Conference agreement

Section 8051 follows the Senate amendment with respect to implementation costs and follows the House bill with respect to the expiration date.

According to CBO, the enactment of section 8051 would result in savings of \$28 million in outlays in FY 1991 and total savings of \$743 million in outlays in FYs 1991-1995.

Line of Duty

Current law

Under section 105(a) of title 38, direct, or primary, effects of willful misconduct are not considered to have been incurred or aggravated in the line of duty. As a result, the disabilities involved are not considered service connected for purposes of VA benefits eligibility. However, section 3.301 of title 38, Code of Federal Regulations, provides for the service-connection of disabilities that are a secondary result of actions that constitute willful misconduct, which VA defines to include the chronic use of alcohol or abuse of drugs. Also, section 105(a) prohibits VA from presuming that venereal disease was due to willful misconduct, provided the veteran

complied with the applicable reporting and treatment regulations of the appropriate service department.

Sections 310, 331, and 521 of title 38 similarly prohibit payment of wartime disability compensation, peacetime disability compensation, and non-service-connected disability pension, respectively, when the veteran's disability is the result of willful misconduct.

House bill

Section 11052 would (1) amend section 105(a) of title 38 to repeal the prohibition against VA presuming that venereal disease resulted from willful misconduct; and (2) amend sections 105(a), 310, 331, and 521 of title 38 to preclude payment of compensation or pension for the secondary effect of willful misconduct. The provision would apply to claims filed after October 31, 1990.

Senate amendment

Section 11052 would provide that injuries or diseases incurred during service as a result of willful misconduct or the abuse of alcohol or drugs will not be considered incurred in the line of duty and thus would not be compensated by VA as a service-connected disability. The provision would apply to line-of-duty determinations made on or after November 1, 1990.

Conference agreement

Section 8052 follows the Senate amendment except that the provisions would take effect with respect to claims filed after October 31, 1990.

The conferees intend the amendments to also preclude payment of compensation for certain secondary effects arising from willful misconduct. For example, payment would be precluded for a back disability or a cardiovascular disability arising as a secondary effect of a foot amputation due to a deliberately self-inflicted wound.

According to CBO, the enactment of section 8052 would result in savings of \$10 million in outlays in FY 1991 and total savings of \$334 million in outlays in FYs 1991-1995.

Requirement for Claimants to Report Social Security Numbers; Uses Of Death Information by the Department of Veterans Affairs

Current law

Section 7(a) of the Privacy Act of 1974 (Public Law No. 93-579), prohibits any Federal agency from denying to any individual a right, benefit, or privilege provided by law because of the individual's refusal to disclose his or her Social Security number. This prohibition does not apply to any disclosure required by Federal statute.

Several statutory provisions allow VA to require disclosure of Social Security numbers (SSNs) by applicants for certain needs-based benefits or for loans made or guaranteed by VA. These provisions are implemented by section 1.575 of title 38, Code of Federal Regulations.

House bill

Section 11053 would require, upon the request of the Secretary, the disclosure of the SSNs of compensation and pension claimants and recipients and their dependents in connection with all claims for these benefits. Benefits would not be paid to an applicant or recipient who fails to provide a requested number, but no person may be required to furnish an SSN of a person who does not have one. Also, under this provision, VA would be required to compare its records regarding recipients of VA compensation or pension benefits with records of the Department of Health and Human Services in order to determine whether any recipient of these benefits is deceased.

Senate amendment

Section 11053 is substantively identical to the House bill except that it also provides that the costs of administering the program of comparing records shall be paid from the VA Compensation and Pension account.

Conference agreement

Section 8053 follows the House bill, except that the costs of administering the program would be paid from funds available for payment of compensation and pension.

According to CBO, enactment of section 8053 would result in savings of \$4 million in outlays in FY 1991 and total savings of \$47 million in outlays for FYs 1991-1995.

TITLE IX—TRANSPORTATION

STATEMENT OF MANAGERS

House bill

Section 9001 of the House bill provided that it is the sense of the House of Representatives that, if any Senate amendment to H.R. 5835 provides for any increase in motor fuel excise taxes or aviation taxes that would be deposited in the Highway Trust Fund or Aviation Trust Fund, respectively, then the managers on the part of the House for the conference on the reconciliation bill should consider provisions which ensure that an amount equal to the estimated tax payments from any such increases enacted shall be made available in the fiscal year collected for highway and aviation purposes, respectively. Such provisions may include provisions similar to those included in the reconciliation submission of the Committee on Public Works and Transportation dated October 12, 1990, to the Committee on the Budget.

Senate bill

No comparable provision.

Conference agreement

Senate receded to the House with an amendment.

In addition to the lifetime capital gains deduction, the bill provides individuals (other than dependents) with a deduction of up to \$1,000 of net capital gains each year. The amount of the deduction is phased out for those with adjusted gross incomes between \$100,000 and \$150,000.

Assets eligible for the annual \$1,000 capital gains deduction are capital assets held for more than one year (including publicly traded assets), but not including collectibles.

Both the lifetime capital gains deduction and the annual \$1,000 capital gains deduction apply to sales or exchanges of assets on or after October 15, 1990.

The bill also provides that all depreciation on real property is recaptured as ordinary income, effective for dispositions on or after October 15, 1990.

Senate Amendment

No provision.

Conference Agreement

The conference agreement does not contain the House bill provision.

B. MODIFICATIONS OF EARNED INCOME TAX CREDIT; DEPENDENT CARE TAX CREDIT

1. EARNED INCOME TAX CREDIT

a. Calculation of basic credit

Present Law

Certain individuals who maintain a home for one or more children are allowed an advance refundable tax credit based on the taxpayer's earned income (sec. 32). In 1990, the earned income tax credit (EITC) is equal to 14 percent of the first \$6,810 of earned income.

The credit is phased out at a rate of 10 percent of the amount of adjusted gross income (or, if greater, earned income) that, in 1990, exceeds \$10,730. The \$6,810 and \$10,730 amounts are adjusted annually for inflation, so that the maximum amount of credit and the maximum amount of income eligible for the credit increase with inflation.

The projected maximum amount of the credit in 1991 is \$994. The actual maximum will depend on future inflation.

House Bill

The House bill modifies the EITC by providing an increase in the rate of the credit. The credit percentage is 18.5 percent for 1991, 19 percent for 1992 and 1993, and 20 percent for 1994 and thereafter. The phase-out percentage is 13 percent in 1991, 13.5 percent in 1992 and 1993, and 14 percent in 1994 and thereafter. The present-law dollar thresholds are retained.

The provision is effective for taxable years beginning after December 31, 1990.

Senate Amendment

The Senate amendment increases the amount of the EITC, modifies the present-law phase-out percentage, and adjusts the credit for family size as follows:

	Credit percentage	Phase-out percentage
For 1991:		
1 qualifying child.....	15.3	10.9
2 or more qual. children.....	15.7	11.2
For 1992:		
1 qualifying child.....	15.95	11.4
2 or more qual. children.....	16.55	11.8
For 1993:		
1 qualifying child.....	17.25	12.3
2 or more qual. children.....	18.25	13.0
For 1994 and thereafter:		
1 qualifying child.....	20.5	14.6
2 or more qual. children.....	22.5	16.1

As under present law, a taxpayer may receive the EITC on an advanced basis. However, the amount of the credit that may be received on this basis is limited to the credit that the taxpayer could receive if the taxpayer had only one qualifying child. If the taxpayer is entitled to receive a larger credit (e.g., by reason of family size), the balance of the credit may be refunded after the taxpayer's income tax return has been filed.

The provision is effective for taxable years beginning after December 31, 1990.

Conference Agreement

The conference agreement follows the House bill and the Senate amendment, except that the credit percentages and phase-out rates are modified and adjusted for family size as follows:

	Credit percentage	Phase-out percentage
For 1991:		
1 qualifying child.....	16.7	11.93
2 or more qual. children.....	17.3	12.36
For 1992:		
1 qualifying child.....	17.6	12.57
2 or more qual. children.....	18.4	13.14
For 1993:		
1 qualifying child.....	18.5	13.21
2 or more qual. children.....	19.5	13.93
For 1994 and thereafter:		
1 qualifying child.....	23	16.43
2 or more qual. children.....	25	17.86

For 1990, the maximum credit is \$1,186 for taxpayers with one qualifying child and \$1,228 for taxpayers with two or more qualifying children.

As under the Senate amendment, the amount of the credit that may be received on an advanced basis is limited to the credit that

the taxpayer could receive if the taxpayer had only one qualifying child.

b. Modification of rules relating to eligibility for EITC

Present Law

The earned income credit is available to: (1) married individuals filing a joint return who are entitled to a dependency exemption for a child, (2) a head of household who resides with a child, or (3) a surviving spouse. In order to qualify to file as a head of household or surviving spouse, a taxpayer must establish that he or she has provided over half of the cost of maintaining the household for the year. In order to be eligible to claim a dependency exemption, the taxpayer, in general, must provide over half of the support for the child, and the child must have the same principal place of abode as the taxpayer for at least half the year. Benefits under the Aid to Families with Dependent Children (AFDC) program and other public assistance programs are not considered support provided by the taxpayer. Thus, for example, if more than half of the taxpayer's income is from AFDC or sources other than the taxpayer's own income, the EITC generally is not available.

House Bill

Under the House bill, in order to qualify for the EITC, the taxpayer must meet the present-law earned income and adjusted gross income thresholds (as modified by the bill). In addition, the taxpayer must have a "qualifying child."

In order to be a qualifying child, an individual must satisfy a relationship test, a residency test, and an age test. The individual satisfies the relationship test if the individual is a son, stepson, daughter, or stepdaughter of the taxpayer, a descendant of a son or daughter of the taxpayer, or a foster or adopted child of the taxpayer. A foster child is defined as an individual whom the taxpayer cares for as the taxpayer's own child. An adopted child includes a child who is legally adopted, or who is placed with the taxpayer by an authorized placement agency for adoption by the taxpayer.

As under present law, if the individual is married at the close of the taxpayer's year, the taxpayer generally must be entitled to a dependency deduction for the taxable year with respect to such individual in order to claim the EITC.

An individual satisfies the residency test if the individual has the same principal place of abode as the taxpayer for more than half the taxable year (the entire year for foster children). It is intended that the determination of whether the residency requirement is met is made under rules similar to those applicable with respect to whether an individual meets the requirements for head-of-household filing status. Thus, for example, certain temporary absences due to education or illness are disregarded for purposes of determining whether the child had the same principal place of abode as the taxpayer for over half the year. As under present law, the residence must be in the United States.

An individual satisfies the age test if the individual (1) has not attained the age of 19 at the close of the taxable year; (2) is a full-

time student who has not attained the age of 24 at the close of the taxable year; or (3) is permanently and totally disabled. Whether a child is a full-time student is determined under the rules relating to the dependency exemption (sec. 151(c)(4)). An individual is permanently and totally disabled if such individual meets the requirements relating to the credit for the disabled (sec. 22(e)(3)).

If, with respect to a taxable year, an individual is a qualifying child with respect to more than one taxpayer, then only the taxpayer with the highest adjusted gross income may claim the EITC with respect to that child for that year. In addition, a taxpayer may not claim the EITC if the taxpayer is a qualifying child.

As under present law, married taxpayers may only claim the EITC if they file a joint return.

Solely for purposes of the EITC, taxpayers are required to obtain and supply a taxpayer identification number (TIN) for each qualifying child who has attained the age of 1 as of the close of the taxable year of the taxpayer.

In order to claim the EITC, the taxpayer must complete and attach a separate schedule to his or her income tax return. In addition to the TIN requirement discussed above, this schedule is required to include the name and age of any qualifying children.

The Internal Revenue Service is to develop special procedures to notify taxpayers who have not claimed the EITC of their potential eligibility for the credit.

The provision is effective for taxable years beginning after December 31, 1990.

Senate Amendment

The Senate amendment is the same as the House bill, except that in addition to the information that may be required on the separate form under the House bill, the Senate agreement permits the Secretary to require adequate proof of the existence of health insurance if the taxpayer has claimed the supplemental EITC for health insurance (e.g., the policy number of the insurance or the employer identification number of the insurance company).

Conference Agreement

The conference agreement follows the House bill and the Senate amendment.

c. Supplemental young child credit

Present Law

Under present law, the EITC is not adjusted by reason of family size or the fact that an infant is under the age of 1 as of the close of the taxable year of the taxpayer.

House Bill

No provision.

Senate Amendment

No provision.

Conference Agreement

If any of the taxpayer's qualifying children are under the age of 1 as of the close of the taxable year of the taxpayer, the conference agreement allows an additional credit. The supplemental young child credit amount is available in addition to the amount determined by family size and is in addition to any supplemental credit for health insurance. Using present-law income limits and phase-out ranges, the supplemental young child credit provides an additional credit percentage of 5 percent and an increased phaseout percentage of 3.57 percent. Thus, the maximum supplemental young child credit is projected to be \$355 in 1991.

If the taxpayer claims the supplemental young child credit, the child that qualifies the taxpayer for such credit is not a qualifying individual under the dependent care credit (sec. 21).

The portion of the credit available under the supplemental credit is not available on an advance basis.

The provision is effective for taxable years beginning after December 31, 1990.

d. Supplemental EITC for certain health insurance premium expenses

Present Law

Expenses for medical care, including health insurance premiums, are deductible to taxpayers who itemize deductions to the extent the expenses exceed 7.5 percent of adjusted gross income (AGI).

Health insurance provided by an employer is excludable from gross income. Self-employed individuals are entitled to deduct 25 percent of the amount of health insurance expenditures; the provision for self-employed individuals expires with respect to expenses for health insurance coverage for periods after September 30, 1990.⁴

Present law does not provide a credit for the cost of health insurance.

House bill

No provision.

Senate Amendment

Under the Senate amendment, a credit is available to taxpayers for qualified health insurance expenses that includes coverage for a qualifying child. The health credit is refundable, but not on an advance basis. The taxpayer may elect not to receive the health credit.

Qualified health insurance expenses for which the credit is available are amounts paid during the taxable year for health insurance coverage that includes one or more qualifying children (as defined for purposes of the EITC). These expenses include those relating to the cost of coverage (i.e., premium cost) only. Thus, expenses such as co-payments or deductibles under the insurance coverage, as

⁴ Sec. 11410 of the bill extends this provision through 1991.

well as other out-of-pocket medical expenses, are not eligible for the credit as qualified health insurance expenses. In addition, qualified health insurance expenses do not include amounts paid by an employee who contributes to his or her employer-sponsored health plan on a pre-tax basis (i.e., through a plan described in sec. 125). Qualified health expenses do include such employee contributions if made on an after-tax basis.

The calculation of the child health credit is generally the same as the calculation of the EITC. Thus, the same eligibility criteria and income phase-in and phase-out requirements apply. However, there is no family size adjustment with respect to the health credit.

The maximum amount of the credit is calculated based on a percentage of earned income. When fully phased in, the credit percentage is 5.5 percent of earned income (up to the maximum amount of creditable earned income in effect for the EITC) and the phaseout rate is 3.9 percent. The credit is phased in so that the credit percentage is 1.1 percent for 1991, 2.475 percent for 1992, 2.5 percent for 1993, and 5.5 percent for 1994 and thereafter. The phase-out percentage is 0.8 percent in 1991, 1.8 percent in 1992 and 1993, and 3.9 percent in 1994 and thereafter.

The maximum credit after application of the phase-out requirement is limited to no more than the actual cost of coverage to the taxpayer for family coverage. Thus, the credit is limited to the lesser of the maximum amount of the credit as phased out with respect to the taxpayer and the actual qualified health insurance expenses.

The amount of expenses against which the credit is allowed reduces the amount of expenses for which the medical expense deduction may be allowed (sec. 213). A similar rule applies with respect to the amount of health insurance expenses upon which the deduction for health insurance costs for self-employed individuals (sec. 162(l)) may be based.

The provision is effective for taxable years beginning after December 31, 1990.

Conference Agreement

The conference agreement follows the Senate amendment, except that the credit percentage is 6 percent and the phase-out rate is 4.285 percent. For 1991, the maximum health credit is projected to be \$426.

The conference agreement deletes the express provision allowing a taxpayer to elect not to receive the credit for health insurance expenses. The conferees intend that, as is the case with respect to the dependent care credit, no formal election is necessary because the taxpayer may choose not to take the credit.

The conference agreement modifies the rule relating to the coordination of the health insurance credit with the medical expense deduction (sec. 213) and the deduction for health insurance expenses for self-employed individuals (sec. 162(l)). Under the conference agreement, the amount of any expenses eligible for the medical expense deduction or health insurance deduction for the self-employed is reduced dollar-for-dollar by the amount of allowable credit under this provision. Thus, for example, assume that a tax-

payer pays a \$3,000 premium for health insurance coverage for the taxpayer and his or her family (including at least one qualifying child), and by reason of such expense is entitled to a \$200 credit under this provision. The amount of expenses (absent any other medical expenses for the taxable year) available to be considered by the taxpayer for purposes of the medical expense deduction under sec. 213 is \$2,800 (\$3,000 less \$200).

e. Treatment of EITC for means-tested programs

Present Law

The AFDC statute provides for the disregard of the EITC from income in determining eligibility and benefits for AFDC recipients. The food stamp statute provides for disregarding the EITC for purposes of determining eligibility and benefits if it is paid as an advance payment. EITC payments received as a lump sum are counted as assets. Some means-tested programs, including housing assistance programs, treat the EITC as income for determining eligibility and benefits.

House Bill

No provision.

Senate Amendment

Under the Senate amendment, the EITC (including the child health insurance portion) is not taken into account as income (for the month in which such refund or payment is made or any month thereafter) or as a resource (for the month in which such refund or payment is made or the following month) for the purpose of determining the eligibility or amount of benefit of such individual for AFDC, Medicaid, SSI, and for low-income housing programs. In addition, effective January 1, 1991, the EITC is not counted as income for purposes of applying the AFDC gross income limit for applicants and recipients of AFDC. A State may waive any AFDC overpayment based on the failure to count the EITC toward the gross income limit between October 1, 1989, and December 31, 1990.

The provision is effective for taxable years beginning after December 31, 1990.

Conference Agreement

The conference agreement follows the Senate amendment, except that the EITC (including the child health insurance portion) is also not taken into account as income (for the month in which such refund or payment is made or any month thereafter) or as a resource (for the month in which such refund or payment is made or the following month) for the purpose of determining the eligibility or amount of benefit of such individual for purposes of the food stamp program and for purposes of certain other housing programs.

furnishing of a notice of proposed deficiency (commonly called a 30-day letter) or the furnishing of a statutory notice of deficiency issued pursuant to section 6212 (commonly called a 90-day letter). In the case of an underpayment of a tax other than an income tax, a notice provided by the IRS that is similar to these notices is treated similarly. For example, a notice under section 6303 is one type of similar notice.

The AFR plus 5 rate applies to the amount determined to be the underpayment, regardless of the amount of tax assessed in the 30-day letter, 90-day letter, or other notice.

The AFR plus 5 rate does not apply to the interest charges that the taxpayer timely assesses against itself in return for using a method of tax accounting or reporting that defers the payment of tax. For example, the AFR plus 5 rate does not apply to the interest charges relating to installment obligations of nondealers (sec. 453A(c)) or passive foreign investment companies (sec. 1291(c)).

The AFR plus 5 rate does not apply to any underpayment of a tax for any taxable period if the underpayment is \$100,000 or less. Underpayments of different types of taxes (e.g., income taxes and employment taxes) as well as underpayments relating to different taxable periods would not be added together for purposes of determining the \$100,000 threshold.

Under present law, the Secretary has the authority to credit the amount of any overpayment against any liability under the Code (sec. 6402). To the extent a portion of tax due is satisfied by a credit of an overpayment, no interest is imposed on that portion of the tax (sec. 6601(f)). The Secretary should implement the most comprehensive crediting procedures under section 6402 that are consistent with sound administrative practice.

The provision is effective for purposes of determining interest for periods after December 31, 1990, regardless of the taxable period (if any) to which the underlying tax may relate.

6. EMPLOYMENT TAX PROVISIONS

- a. Increase dollar limitation on amount of wages and self-employment income subject to the Medicare hospital insurance payroll tax

Present Law

As part of the Federal Insurance Contributions Act (FICA), a tax is imposed on employees and employers up to a maximum amount of employee wages. The tax is comprised of two parts: old-age, survivor, and disability insurance (OASDI) and Medicare hospital insurance (HI). For wages paid in 1990 to covered employees, the HI tax rate is 1.45 percent on both the employer and the employee on the first \$51,300 of wages and the OASDI tax rate is 6.2 percent on both the employer and the employee on the first \$51,300 of wages.

Under the Self-Employment Contributions Act of 1954 (SECA), a tax is imposed on an individual's self-employment income. The self-employment tax rate is the same as the total rate for employers and employees (i.e., 2.9 percent for HI and 12.40 percent for OASDI). For 1990, the tax is applied to the first \$51,300 of self-employment income and, in general, the tax is reduced to the extent

that the individual had wages for which employment taxes were withheld during the year.

The cap on wages and self-employment income subject to FICA and SECA taxes is indexed to changes in the average wages in the economy. In 1991, the amount of wages or self-employment income subject to the tax will be \$53,400.

House Bill

The House bill increases the cap on wages and self-employment income considered in calculating HI tax liability to \$100,000. As under present law, for years beginning after 1991, this cap is indexed to changes in the average wages in the economy. The OASDI wage cap remains at the level provided under present law.

The provision is effective on January 1, 1991.

Senate Amendment

The Senate amendment is the same as the House bill, except that the cap considered in calculating HI tax liability is increased to \$89,000.

Conference Agreement

The conference agreement follows the House bill and the Senate amendment except that the cap considered in calculating HI tax liability is increased to \$125,000.

- b. Extend Medicare coverage of, and application of hospital insurance tax to, all State and local government employees

Present Law

Before enactment of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), State and local workers were covered under Medicare only if the State and the Secretary of Health and Human Services entered into a voluntary agreement providing for coverage under the social security and Medicare programs (OASDI and HI). In COBRA, the Congress extended Medicare coverage (and the corresponding hospital insurance payroll tax) on a mandatory basis to State and local government employees (other than students) hired after March 31, 1986.

For wages paid in 1990 to Medicare-covered employees, the total HI tax rate is 2.9 percent of the first \$51,300 of wages. In 1991, the amount of wages subject to tax will be \$53,400. The tax is divided equally between the employer and the employee.

House Bill

No provision.

Senate Amendment

The Senate amendment requires coverage of all employees of State and local governments under Medicare without regard to the employee's date of hire. The 2.9-percent HI payroll tax rate is phased in with respect to newly covered State and local govern-

ment employees so that the tax rate is 1.6 percent in 1992, 2.7 percent in 1993, and 2.9 percent in 1994 and thereafter. The present-law student exception is retained with respect to students employed in public schools, colleges, and universities. As under present law, coverage may be provided to such individuals at the option of the State government.

In the case of certain employees who are required to pay the HI tax as a result of the provision and who meet certain other requirements, State and local service prior to the effective date of the provision is deemed to have been covered by the HI tax for purposes of determining Medicare eligibility. Prior State and local service is counted regardless of whether such service was continuous.

Under the provision, the HI trust fund is reimbursed from the general fund of the Treasury for any additional cost arising by reason of this provision.

The Secretary of Health and Human Services is required to provide a process by which employees may provide evidence of prior State and local governmental service if such service is necessary to qualify for coverage under the program.

The provision is effective with respect to services performed after December 31, 1991.

Conference Agreement

The conference agreement does not include the Senate amendment.

- c. Extend social security coverage (OASDHI) to State and local government employees not covered by a public employee retirement program

Present Law

Under present law, employees of State and local governments are covered under social security by voluntary agreements entered into by the States with the Secretary of Health and Human Services (HHS). After a State has entered into such an agreement, it may decide, or permit its political subdivisions to decide, whether to include particular groups of employees under the agreement. All States have entered into such agreements. The extent of coverage is high in some States and limited in others. Nationally, about 72 percent of State and local workers are covered by social security.

With certain exceptions, a State has broad latitude to decide which groups of State and local employees are covered under its agreement. In some cases in which States have elected not to provide coverage, a part of the workforce does not participate in any public retirement plan.

For 1990, the social security (Old Age, Survivors, and Disability Insurance) tax rate is 6.2 percent of covered wages up to \$51,300 and is imposed on both the employer and employee (for a total of 12.40 percent). In 1991, the amount of wages subject to tax is \$53,400.

As part of the Federal Insurance Contributions Act (FICA), a Medicare hospital insurance tax is imposed (HI). For wages paid in

1990 to covered employees, the HI tax rate is 1.45 percent on both the employer and the employee on the first \$51,300 of wages.

House Bill

The House bill requires social security (Old Age, Survivors, and Disability Insurance) coverage for State and local workers who are not covered by a State voluntary agreement or a retirement system in conjunction with their employment for the State or local government and subjects the wages of such employees to the OASDI tax under the Federal Insurance Contributions Act (FICA). An exception is provided for students employed in public schools, colleges, and universities, for whom coverage may, as under present law, be provided at the option of the State government. This exception maintains parallel coverage rules for students employed by public educational institutions and those employed by private schools, colleges, and universities.

A retirement system is defined as under the definition of retirement system in the Social Security Act (42 U.S.C. sec. 418(b)(4)). Thus, a retirement system is defined as a pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision thereof.

Whether an employee is a member (i.e., is a participant) of a retirement system is based upon whether that individual actually participates in the program. Thus, whether an employee participates is not determined by whether that individual holds a position that is included in a retirement system. Instead, that individual must actually be a member of the system. For example, an employee (whose job classification is of a type that ordinarily is entitled to coverage) is not a member of a retirement system if he or she is ineligible because of age or service conditions contained in the plan and, therefore, is required to be covered under social security. Similarly, if participation in the system is elective, and the employee elects not to participate, that employee does not participate in a system for purposes of this rule, and is to be covered under the social security system.

The Secretary of the Treasury, in conjunction with the Social Security Administration, is required to issue guidance in order to implement the purposes of this provision.

The provision is effective with respect to services performed after December 31, 1990.

Senate Amendment

The Senate amendment is the same as the House bill, except that the provision is effective with respect to services performed after December 31, 1991.

Conference Agreement

The conference agreement follows the House bill and Senate amendment, except that the provision is effective with respect to services performed after June 30, 1991.

As under the House bill and Senate amendment, an exception is provided for students employed in public schools, colleges, and uni-

versities, for whom coverage may, as under present law, be provided at the option of the State government. The conference agreement also contains other exceptions as contained in the House bill and Senate amendment (e.g., service by an election official or election worker if the remuneration paid in a calendar year for such service is less than \$100).

The conference agreement follows the House bill and the Senate amendment with respect to the definition of retirement system, except that the Secretary of the Treasury and the Social Security Administration are authorized to provide guidance under which a particular plan or class of plans will not be considered a retirement system if such characterization is necessary to effectuate the purposes of this provision.

The conference agreement follows the House bill and Senate amendment in that whether an employee is a member (i.e., is a participant) of a retirement system is based upon whether that individual actually participates in the program. Thus, whether an employee participates is not determined by whether that individual holds a position that is included in a retirement system. Instead, that individual must actually be a member of the system. For example, an employee (whose job classification is of a type that ordinarily is entitled to coverage) is not a member of a retirement system if he or she is ineligible because of age or service conditions contained in the plan and, therefore, is required to be covered under social security. Similarly, if participation in the system is elective, and the employee elects not to participate, that employee does not participate in a system for purposes of this rule, and is to be covered under the social security system.

Except as otherwise provided under the conference agreement, or in guidance promulgated by the Secretary of the Treasury, rules similar to those applicable in determining whether an individual is an active participant for purposes of contributing to an individual retirement account (Code sec. 219) apply in determining whether a specific employee is a member of a retirement system.

The conference agreement extends Medicare coverage to, and applies the HI tax with respect to the wages of, those employees (otherwise not already subject to the HI tax) who become subject to OASDI by reason of this provision.

d. Extend Federal Unemployment Tax (FUTA) surtax

Present Law

The Federal Unemployment Act (FUTA) imposes a gross employer tax of 6.2 percent on the first \$7,000 paid annually to each employee. This 6.2-percent rate includes a temporary surtax of 0.2 percent. Employers in States meeting certain requirements and with no overdue Federal loans are eligible for a full 5.4-percentage point credit, making the basic net FUTA tax rate 0.8 percent. The 0.2-percent surtax is scheduled to expire for wages paid after 1990, after which the basic net FUTA tax rate will be 0.6 percent.

House Bill

The House bill extends the 0.2-percent surtax imposed on employers under the Federal Unemployment Tax Act (FUTA) through 1995.

The provision is effective with respect to wages paid on or after January 1, 1991.

Senate Amendment

The Senate amendment is the same as the House bill.

Conference Agreement

The conference agreement follows the House bill and the Senate amendment.

e. Increase in railroad retirement tier 2 payroll taxes

Present Law

Railroad employers, employees, and employee representatives are subject to a payroll tax to fund tier 2 railroad retirement benefits. The tax rate is 4.90 percent for employees, 16.10 percent for employers, and 14.75 percent for employee representatives. In 1990, the tax is imposed on wages up to a maximum of \$38,100. In 1991, this wage base will be \$39,600.

House Bill

No provision.

Senate Amendment

The Senate amendment increases the tier 2 tax rate by 0.10 percent for employees (for a total rate of 5.00 percent), 0.30 percent for employers (for a total rate of 16.40 percent), and 0.30 percent for employee representatives (for a total rate of 15.05 percent).

The provision applies to compensation paid after December 31, 1990, in the case of the employer tax and to compensation received after December 31, 1990, in the case of the employee and employee representative taxes.

Conference Agreement

The conference agreement does not include the Senate amendment.

f. Payroll tax deposit stabilization

Present Law

Treasury regulations have established the system under which employers deposit income taxes withheld from employees' wages and FICA taxes. The frequency with which these taxes must be deposited increases as the amount required to be deposited increases.

Employers are required to deposit these taxes as frequently as eight times per month, provided that the amount to be deposited

equals or exceeds \$3,000. These deposits must be made within three banking days after the end of the eighth-monthly period.

Effective August 1, 1990, employers who are on this eighth-monthly system are required to deposit income taxes withheld from employees' wages and FICA taxes by the close of the applicable banking day (instead of by the close of the third banking day) after any day on which the business cumulates an amount to be deposited equal to or greater than \$100,000 (regardless of whether that day is the last day of an eighth-monthly period).

For 1990, the applicable banking day is the first. For 1991, the applicable banking day is the second. For 1992, the applicable banking day is the third. For 1993 and 1994, the applicable banking day is the first. The Treasury Department is given authority to issue regulations for 1995 and succeeding years to provide for similar modifications to the date by which deposits must be made in order to minimize unevenness in the receipts effects of this provision.

House Bill

The House bill requires that deposits equal to or greater than \$100,000 must be made by the close of the next banking day for all years. Thus, no change from present law is necessary for calendar year 1990, but for calendar years 1991 and 1992 deposits are accelerated. The regulatory authority provided to the Treasury Department is repealed. The provision is effective for amounts required to be deposited after December 31, 1990.

Senate Amendment

The Senate amendment is the same as the House bill.

Conference Agreement

The conference agreement follows the House bill and the Senate amendment.

7. TRUSTS WITH FOREIGN GRANTORS

Present Law

A grantor who transfers property to a trust while retaining certain powers or interests over the trust is treated as owner of the trust for income tax purposes under the so-called "grantor trust rules." If a grantor or other person is treated as the owner of a trust, the income and deductions of the trust are included directly in the grantor's taxable income. The nominal grantor is not treated as the grantor if another party is in fact the grantor.

House Bill

The House bill provides that a U.S. person who is a beneficiary of a trust is treated as the grantor to the extent that the beneficiary transferred property, directly or indirectly, to a foreign person who otherwise would have been treated as the owner under the "grantor trust rules." This rule would apply even if the beneficiary

The timetable for sequestration reports and orders is as follows:

Date	Action
5 days before the budget	CBO sequestration preview report.
President's budget submission	OMB sequestration preview report.
August 15	CBO sequestration update report.
August 20	OMB sequestration update report.
10 days after end of session	CBO final sequestration report.
15 days after end of session	OMB final sequestration report.
30 days later	GAO compliance report.

This timetable continues the feature of current law in which CBO issues its reports 5 days before OMB, and OMB is required to explain differences between its estimates and those of OMB.

All 3 sequestration reports will contain updated estimates of the maximum deficit amount and the discretionary spending limits for each category. They will also contain estimates of any net deficit increase or decrease (under the pay-as-you-go provisions), any excess deficit (compared to the deficit target), and the sequestration reductions and percentages necessary to eliminate a deficit increase or excess deficit. The final sequestration reports will include estimates of new budget authority and outlays for each discretionary spending category, the amounts of any breach in the discretionary spending limits, and the sequestration percentages necessary to eliminate a breach. In addition, the final reports will contain, for each budget account to be sequestered, estimates of the baseline level of sequestrable budgetary resources and outlays and the required reductions.

An extra pair of sequestration reports and an additional Presidential order will be required if, after the final sequestration report but before July 1, enactment of an appropriation bill causes a discretionary spending breach. These within-session sequestration reports are to contain the same information regarding discretionary spending as a final end-of-session sequestration report.

VI. TREATMENT OF SOCIAL SECURITY

Current law

Under current law, the Social Security trust funds are off-budget but are included in deficit estimates and calculations made for purposes of the sequestration process. However, Social Security benefit payments are exempt from any sequestration order.

Section 310(g) of the Congressional Budget Act of 1974 prohibits the consideration of reconciliation legislation "that contains recommendations" with respect to Social Security. (A motion to waive this point of order requires 60 votes in the Senate and a simple majority in the House.)

House bill

The House bill reaffirms the off-budget status of Social Security and removes the trust funds—excluding interest receipts—from the deficit estimates and calculations made in the sequestration process. The House bill retains the current law exemption of Social Security benefit payments from any sequestration order.

The House bill creates a "fire wall" point of order (as free-standing legislation) to prohibit the consideration of legislation that would change the actuarial balance of the Social Security trust funds over a 5-year or 75-year period. In the case of legislation decreasing Social Security revenues, the prohibition would not apply if the legislation also included an equivalent increase in Medicare taxes for the period covered by the legislation.

Senate amendment

The Senate amendment also reaffirms the off-budget status of Social Security and removes the trust funds from the deficit estimates and calculations made in the sequestration process. However, unlike the House bill, the Senate amendment removes the gross trust fund transactions—including interest receipts—from the sequestration deficit calculations. The Senate amendment also retains the current law exemption of Social Security benefit payments from any sequestration order.

The Senate amendment also creates a procedural fire wall to protect Social Security financing, but does so by expanding certain budget enforcement provisions of the Congressional Budget Act of 1974. The Senate amendment expands the prohibition in Section 310(g) of the Budget Act to specifically protect Social Security financing, prohibits the consideration of a reported budget resolution calling for a reduction in Social Security surplus, and includes Social Security in the enforcement procedures under Sections 302 and 311 of the Budget Act. The Senate amendment also requires the Secretary of Health and Human Services to provide an actuarial analysis of any legislation affecting Social Security, and generally prohibits the consideration of legislation lacking such an analysis.

For more on the budgetary treatment of Social Security under current law and historically, see SENATE COMM. ON THE BUDGET, SOCIAL SECURITY PRESERVATION ACT, S. REP. NO. 101-426, 101ST Cong. 2d Sess. (1990).

Conference agreement

The conference agreement incorporates the Senate position on the budgetary treatment of the Social Security trust funds, reaffirming their off-budget status and removing all their transactions from the deficit estimates and calculations made in the sequestration process.

Further, the conference agreement provides that the "fire wall" procedure proposed by the House shall apply only to the House and that the "fire wall" procedures proposed by the Senate shall apply only to the Senate.

VII. CREDIT REFORM

Current law

The credit programs of the Federal Government are displayed in the budget on a cash accounting basis. Cash accounting overstates the real economic cost of direct loan programs and understates the real economic costs of loan guarantee programs in the year loans are made.

Finder's Aid

P.L. 101-517 (104 Stat. 2190) Approved November 5, 1990
Departments of Labor, Health and Human Services,
and Education, and Related Agencies Appropriations Act, 1991

Note: There are no amendments to the Social Security Act contained in this Public Law.
The provisions included here deal with appropriations for programs administered under
the Social Security Act.

Public Law 101-517
101st Congress

An Act

Nov. 5, 1990
[H.R. 5257]

Making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies, for the fiscal year ending September 30, 1991, and for other purposes.

Departments of
Labor, Health
and Human
Services, and
Education, and
Related
Agencies
Appropriations
Act, 1991.
Department of
Labor
Appropriations
Act, 1991.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 1991, and for other purposes, namely:

TITLE I—DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

PROGRAM ADMINISTRATION

For expenses of administering employment and training programs, \$71,480,000, together with not to exceed \$54,301,000, which may be expended from the Employment Security Administration account in the Unemployment Trust Fund.

TRAINING AND EMPLOYMENT SERVICES

For expenses necessary to carry into effect the Job Training Partnership Act, including the purchase and hire of passenger motor vehicles, the construction, alteration, and repair of buildings and other facilities, and the purchase of real property for training centers as authorized by the Job Training Partnership Act, \$4,098,236,000, plus reimbursements, to be available for obligation for the period July 1, 1991, through June 30, 1992, of which \$61,097,000 shall be for carrying out section 401, \$72,024,000 shall be for carrying out section 402, \$9,345,000 shall be for carrying out section 441, \$1,894,000 shall be for the National Commission for Employment Policy, \$4,250,000 shall be for all activities conducted by and through the National Occupational Information Coordinating Committee under the Job Training Partnership Act, and \$4,000,000 shall be for service delivery areas under section 101(a)(4)(A)(iii) of the Job Training Partnership Act in addition to amounts otherwise provided under sections 202 and 251(b) of the Act; and, in addition, \$68,920,000 is appropriated for the Job Corps, in addition to amounts otherwise provided herein for the Job Corps, to be available for obligation for the period July 1, 1991 through June 30, 1994; and in addition, \$11,500,000 is appropriated for activities authorized by title VII, subtitle C of the Stewart B. McKinney Homeless Assistance Act: *Provided*, That no funds from any other appropriation shall be used to provide meal services at or for Job Corps centers.

ASSISTANT SECRETARY FOR HEALTH

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

For the expenses necessary for the Office of Assistant Secretary for Health and for carrying out titles III, XVII, XX, and XXI of the Public Health Service Act, \$69,540,000, and, in addition, amounts received by the Public Health Service from Freedom of Information Act fees, reimbursable and interagency agreements and the sale of data tapes shall be credited to this appropriation and shall remain available until expended.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

For retirement pay and medical benefits of Public Health Service Commissioned Officers as authorized by law, and for payments under the Retired Serviceman's Family Protection Plan and Survivor Benefit Plan and for medical care of dependents and retired personnel under the Dependents' Medical Care Act (10 U.S.C. ch. 55), and for payments pursuant to section 229(b) of the Social Security Act (42 U.S.C. 429(b)), such amounts as may be required during the current fiscal year.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH

HEALTH CARE POLICY AND RESEARCH

For carrying out titles III and IX of the Public Health Service Act, and Part A of title XI of the Social Security Act, \$98,887,000 together with not to exceed \$5,000,000 to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as authorized by section 1142 of the Social Security Act and not to exceed \$1,037,000 to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as authorized by section 201(g) of the Social Security Act; and, in addition, amounts received from Freedom of Information Act fees, reimbursable and interagency agreements, and the sale of data tapes shall be credited to this appropriation and shall remain available until expended: *Provided*, That the amount made available pursuant to section 926(b) of the Public Health Service Act shall not exceed \$13,776,000.

HEALTH CARE FINANCING ADMINISTRATION

GRANTS TO STATES FOR MEDICAID

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, \$36,966,394,000, to remain available until expended.

For making, after May 31, 1991, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 1991 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States under title XIX of the Social Security Act for the first quarter of fiscal year 1992, \$13,500,000,000, to remain available until expended.

Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such

quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

PAYMENTS TO HEALTH CARE TRUST FUNDS

For payment to the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as provided under sections 217(g) and 1844 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248, \$35,335,000,000.

PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, and XIX of the Social Security Act, title XIII of the Public Health Service Act, the Clinical Laboratory Improvement Amendments of 1988, and section 4005(e) of Public Law 100-203, as amended, \$105,466,000, together with not to exceed \$2,029,138,000 to be transferred to this appropriation as authorized by section 201(g) of the Social Security Act, from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds: *Provided*, That \$136,500,000 of said trust funds shall be expended only to the extent necessary to meet unanticipated costs of agencies or organizations with which agreements have been made to participate in the administration of title XVIII and after maximum absorption of such costs within the remainder of the existing limitation has been achieved: *Provided further*, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the Public Health Service Act are to be credited to this appropriation: *Provided further*, That all funds collected in accordance with section 353 of the Public Health Service Act are to be credited to this appropriation to remain available until expended.

SOCIAL SECURITY ADMINISTRATION

PAYMENTS TO SOCIAL SECURITY TRUST FUNDS

For payment to the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds, as provided under sections 201(m), 228(g), and 1131(b)(2) of the Social Security Act, \$46,958,000.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

For carrying out title IV of the Federal Mine Safety and Health Act of 1977, including the payment of travel expenses on an actual cost or commuted basis, to an individual, for travel incident to medical examinations, and when travel of more than 75 miles is required, to parties, their representatives, and all reasonably necessary witnesses for travel within the United States, Puerto Rico, and the Virgin Islands, to reconsideration interviews and to proceedings before administrative law judges, \$626,081,000, to remain available until expended: *Provided*, That monthly benefit payments shall be paid consistent with section 215(g) of the Social Security Act.

For making, after July 31 of the current fiscal year, benefit payments to individuals under title IV of the Federal Mine Safety and Health Act of 1977, for costs incurred in the current fiscal year, such amounts as may be necessary.

For making benefit payments under title IV of the Federal Mine Safety and Health Act of 1977 for the first quarter of fiscal year 1992, \$203,000,000, to remain available until expended.

SUPPLEMENTAL SECURITY INCOME PROGRAM

For carrying out the Supplemental Security Income Program, title XI of the Social Security Act, section 401 of Public Law 92-603, section 212 of Public Law 93-66, as amended, and section 405 of Public Law 95-216, including payment to the Social Security trust funds for administrative expenses incurred pursuant to section 201(g)(1) of the Social Security Act, \$14,031,394,000, to remain available until expended: *Provided*, That any portion of the funds provided to a State in the current fiscal year and not obligated by the State during that year shall be returned to the Treasury: *Provided*, That all collections from repayments of overpayments shall be deposited in the general fund of the Treasury.

For making, after July 31 of the current fiscal year, benefit payments to individuals under title XVI of the Social Security Act, for unanticipated costs incurred for the current fiscal year, such sums as may be necessary.

For carrying out the Supplemental Security Income Program for the first quarter of fiscal year 1992, \$3,550,000,000, to remain available until expended.

LIMITATION ON ADMINISTRATIVE EXPENSES

For necessary expenses, not more than \$4,316,974,000 may be expended, as authorized by section 201(g)(1) of the Social Security Act, from any one or all of the trust funds referred to therein: *Provided*, That travel expense payments under section 1631(h) of such Act for travel to hearings may be made only when travel of more than seventy-five miles is required: *Provided further*, That \$150,000,000 of the foregoing amount shall be apportioned for use only to the extent necessary to process workloads not anticipated in the budget estimates, for automation projects and their impact on the work force, and to meet mandatory increases in costs of agencies or organizations with which agreements have been made to participate in the administration of titles XVI and XVIII and section 221 of the Social Security Act, and after maximum absorption of such costs within the remainder of the existing limitation has been achieved: *Provided further*, That none of the funds appropriated by this Act may be used for the manufacture, printing, or procuring of social security cards, as provided in section 205(c)(2)(D) of the Social Security Act, where paper and other materials used in the manufacture of such cards are produced, manufactured, or assembled outside of the United States.

42 USC 1383
note.

FAMILY SUPPORT ADMINISTRATION

FAMILY SUPPORT PAYMENTS TO STATES

For making payments to States or other non-Federal entities, except as otherwise provided, under titles I, IV-A and -D, X, XI, XIV, and XVI of the Social Security Act, and the Act of July 5, 1960 (24 U.S.C. ch. 9), \$10,172,346,000, to remain available until expended.

For making, after May 31 of the current fiscal year, payments to States or other non-Federal entities under titles I, IV-A and -D, X,

XI, XIV, and XVI of the Social Security Act, for the last three months of the current year for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or other non-Federal entities under titles I, IV-A and -D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch. 9) for the first quarter of fiscal year 1992, \$3,300,000,000 to remain available until expended.

PAYMENTS TO STATES FOR AFDC WORK PROGRAMS

For carrying out aid to families with dependent children work programs, as authorized by part F of title IV of the Social Security Act, \$1,000,000,000.

LOW INCOME HOME ENERGY ASSISTANCE

For making payments under title XXVI of the Omnibus Budget Reconciliation Act of 1981, \$1,450,000,000, of which \$74,610,000 shall become available for making payments on September 30, 1991.

ENERGY EMERGENCY CONTINGENCY FUND

For the purpose of establishing an "Energy Emergency Contingency Fund", in the United States Treasury to be available for grants to the fifty States, the District of Columbia, and Indian tribes and tribal organizations receiving direct funding in fiscal year 1991 under the Low-Income Home Energy Assistance Act of 1981, \$200,000,000 which shall be available for obligation after January 15, 1991: *Provided*, That the national average retail price of home heating oil in any of the months December 1990, January 1991, or February 1991, as reported for Petroleum Marketing Monthly by the Energy Information Administration or the best available data from the Department of Energy on the last day of the month following such month, exceeds by 20 per centum or more the average of the national average retail price for home heating oil for the corresponding month as reported by the Department of Energy for 1986, 1987, 1988, and 1989: *Provided further*, That these funds shall be allotted to the fifty States and the District of Columbia in proportion to the consumption by low-income households in such jurisdiction (determined on the basis of the best data available at the time of allotment) of home heating oil: *Provided further*, That for allotment purposes only, home heating oil includes liquified petroleum gas and kerosene: *Provided further*, That Indian tribes and tribal organizations shall receive the same per centum of the allotment of the State or States in which they are located as they receive from that State's (or those States') allotment for fiscal year 1991 under section 2604 of the Low-Income Home Energy Assistance Act.

Low-income
persons.

Indians.

REFUGEE AND ENTRANT ASSISTANCE

For making payments for refugee and entrant assistance activities authorized by title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96-422), \$420,770,000, of which \$240,000,000 shall be available for State cash and medical assistance.

INTERIM ASSISTANCE TO STATES FOR LEGALIZATION

8 USC 1255a
note.

Section 204(a)(1)(B) of the Immigration Reform and Control Act of 1986 is amended by striking the period at the end thereof and inserting in its place the following: “, and funds appropriated for fiscal year 1991 under this section are reduced by \$566,854,000.”.

Section 204(a)(1)(C) of the Immigration Reform and Control Act of 1986 is amended—

(1) by striking “\$1,000,000,000” and inserting in its place “\$2,000,000,000”;

(2) by inserting “for each of fiscal years 1990 and 1991” after “paragraph (2)”; and

(3) by striking the period at the end thereof and inserting in its place the following: “and fiscal year 1991.”.

COMMUNITY SERVICES BLOCK GRANT

For making payments under the Community Services Block Grant Act and the Stewart B. McKinney Homeless Assistance Act, \$438,300,000, of which \$21,000,000 shall be for carrying out section 681(a)(2)(A), \$4,200,000 shall be for carrying out section 681(a)(2)(D), \$3,100,000 shall be for carrying out section 681(a)(2)(E), \$11,100,000 shall be for carrying out section 681(a)(2)(F), \$250,000 shall be for carrying out section 681(a)(3), \$4,150,000 shall be for carrying out section 408 of Public Law 99-425, and \$2,500,000 shall be for carrying out section 681A with respect to the community food and nutrition program.

PROGRAM ADMINISTRATION

For necessary administrative expenses to carry out titles I, IV, X, XI, XIV, and XVI of the Social Security Act, the Act of July 5, 1960 (24 U.S.C. ch. 9), title XXVI of the Omnibus Budget Reconciliation Act of 1981, the Community Services Block Grant Act, title IV of the Immigration and Nationality Act, section 501 of the Refugee Education Assistance Act of 1980, Public Law 100-77, and section 126 and titles IV and V of Public Law 100-485, \$86,450,000, to be reduced by such sums as may be collected, which shall be credited to this account as offsetting collections, from fees authorized under section 453 of the Social Security Act: *Provided*, That funds appropriated in Public Law 101-166 for the Commission on Interstate Child Support shall remain available through September 30, 1991.

ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

SOCIAL SERVICES BLOCK GRANT

For carrying out the Social Services Block Grant Act, \$2,800,000,000.

HUMAN DEVELOPMENT SERVICES

For carrying out, except as otherwise provided, the Runaway and Homeless Youth Act, the Older Americans Act of 1965, the Developmental Disabilities Assistance and Bill of Rights Act, chapter 8-D of title VI of the Omnibus Budget Reconciliation Act of 1981, the Head Start Act, the Child Development Associate Scholarship Assistance Act of 1985, the Child Abuse Prevention and Treatment

Act, chapters 1 and 2 of subtitle B of title III of the Anti-Drug Abuse Act of 1988, the Family Violence Prevention and Services Act (title III of Public Law 98-457), the Native American Programs Act, title II of Public Law 95-266 (adoption opportunities), section 206 of the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act of 1986, the Comprehensive Child Development Centers Act of 1988, the Abandoned Infants Assistance Act of 1988, section 10404 of Public Law 101-239 and part B of title IV and section 1110 of the Social Security Act, \$3,519,699,000, of which \$1,000,000 shall remain available until expended for the 1991 White House Conference on Aging.

For carrying out the Child Care and Development Block Grant Act of 1990, \$750,000,000 which shall become available for obligation on September 7, 1991: *Provided*, That these funds shall only become available upon enactment into law of authorizing legislation.

PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE

For carrying out part E of title IV of the Social Security Act, \$2,611,281,000, of which \$520,911,000 shall be for payment of prior years' claims: *Provided*, That of the total amount provided, \$27,352,000 shall be transferred to the "Human Development Services" account for part B of title IV of the Act.

OFFICE OF THE SECRETARY

GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management, including hire of six medium sedans, \$81,350,000, of which \$20,995,000 shall be available for expenses necessary for the Office of the General Counsel, together with \$31,100,000, of which \$26,881,000 shall be available for expenses necessary for the Office of the General Counsel, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from any one or all of the trust funds referred to therein.

OFFICE OF THE INSPECTOR GENERAL

For expenses necessary for the Office of the Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, \$53,500,000, together with not to exceed \$43,723,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from any one or all of the trust funds referred to therein.

OFFICE FOR CIVIL RIGHTS

For expenses necessary for the Office for Civil Rights, \$17,585,000, together with not to exceed \$4,000,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from any one or all of the trust funds referred to therein.

POLICY RESEARCH

For carrying out, to the extent not otherwise provided, research studies under section 1110 of the Social Security Act, \$9,167,000: *Provided*, That not less than \$3,150,000 shall be obligated to con-

tinue research on poverty conducted by the Institute for Research on Poverty.

GENERAL PROVISIONS

SEC. 201. None of the funds made available by this Act for the National Institutes of Health, except for those appropriated to the "Office of the Director", may be used to provide forward funding or multiyear funding of research project grants except in those cases where the Director of the National Institutes of Health has determined that such funding is specifically required because of the scientific requirements of a particular research project grant.

SEC. 202. Appropriations in this or any other Act shall be available for expenses for active commissioned officers in the Public Health Service Reserve Corps and for not to exceed 2,400 commissioned officers in the Regular Corps; expenses incident to the dissemination of health information in foreign countries through exhibits and other appropriate means; advances of funds for compensation, travel, and subsistence expenses (or per diem in lieu thereof) for persons coming from abroad to participate in health or scientific activities of the Department pursuant to law; expenses of primary and secondary schooling of dependents in foreign countries, of Public Health Service commissioned officers stationed in foreign countries, at costs for any given area not in excess of those of the Department of Defense for the same area, when it is determined by the Secretary that the schools available in the locality are unable to provide adequately for the education of such dependents, and for the transportation of such dependents, between such schools and their places of residence when the schools are not accessible to such dependents by regular means of transportation; expenses for medical care for civilian and commissioned employees of the Public Health Service and their dependents, assigned abroad on a permanent basis in accordance with such regulations as the Secretary may provide; rental or lease of living quarters (for periods not exceeding five years), and provision of heat, fuel, and light and maintenance, improvement, and repair of such quarters, and advance payments therefor, for civilian officers, and employees of the Public Health Service who are United States citizens and who have a permanent station in a foreign country; purchase, erection, and maintenance of temporary or portable structures; and for the payment of compensation to consultants or individual scientists appointed for limited periods of time pursuant to section 207(f) or section 207(g) of the Public Health Service Act, at rates established by the Assistant Secretary for Health, or the Secretary where such action is required by statute, not to exceed the per diem rate equivalent to the rate for GS-18.

SEC. 203. None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.

SEC. 204. Funds advanced to the National Institutes of Health Management Fund from appropriations in this Act shall be available for the expenses of sharing medical care facilities and resources pursuant to section 327A of the Public Health Service Act.

SEC. 205. Funds appropriated in this title shall be available for not to exceed \$37,000 for official reception and representation expenses when specifically approved by the Secretary.

for salaries and expenses under titles I and III, respectively, for official reception and representation expenses; the Director of the Federal Mediation and Conciliation Service is authorized to make available for official reception and representation expenses not to exceed \$2,500 from the funds available for "Salaries and expenses, Federal Mediation and Conciliation Service"; and the Chairman of the National Mediation Board is authorized to make available for official reception and representation expenses not to exceed \$2,500 from funds available for "Salaries and expenses, National Mediation Board".

SEC. 511. When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds, including but not limited to State and local governments, shall clearly state (1) the percentage of the total costs of the program or project which will be financed with Federal money, (2) the dollar amount of Federal funds for the project or program, and (3) percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

Wages.

SEC. 512. Such sums as may be necessary for fiscal year 1991 pay raises for programs funded by this Act shall be absorbed within the levels appropriated in this Act.

Drugs.
Health.

SEC. 513. None of the funds appropriated under this Act shall be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the President of the United States certifies that such programs are effective in stopping the spread of HIV and do not encourage the use of illegal drugs.

SEC. 514. (a) Notwithstanding any other provision of this Act, funds appropriated for salaries and expenses of the Department of Labor are hereby reduced by \$9,000,000; salaries and expenses of the Department of Education are hereby reduced by \$5,000,000; and salaries and expenses of the Department of Health and Human Services are hereby reduced by \$50,000,000: *Provided*, That no trust fund limitation shall be reduced with the exception of the Social Security Administration, Limitation on Administrative Expenses, which is hereby reduced by \$57,000,000.

(b) Notwithstanding any other provision of this Act, funds appropriated or otherwise made available which are not mandated by law for programs, projects or activities funded by this Act shall be reduced by 2.41 per centum.

SEC. 515. For purposes of section 202 of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987, transfers, if any, in the following accounts are a necessary (but secondary) result of significant policy changes: State Unemployment Insurance and Employment Service Operations; Low Income Home Energy Assistance; Interim Assistance to States for Legalization; and Human Development Services.

IMPACT AID

SEC. 516. Section 5(e)(1)(D) of Public Law 81-874 (as amended) (20 U.S.C. 240) (hereafter in this section referred to as the "Act") shall not apply to any local educational agency that was an agency described in section 5(c)(2)(A)(ii) of the Act in fiscal year 1990 but is an agency described in section 5(c)(2)(A)(iii) in fiscal year 1991 as a result of families moving off base due to a landfill or health concern

or an environmental hazard, or due to risk assessment, investigation, testing or remediation for such concern or hazard, and any such local educational agency shall be deemed to belong to the category described in section 5(c)(2)(A)(ii) for fiscal year 1991.

This Act may be cited as the "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1991".

Approved November 5, 1990.

LEGISLATIVE HISTORY—H.R. 5257:

HOUSE REPORTS: No. 101-591 (Comm. on Appropriations) and No. 101-908 (Comm. of Conference).

SENATE REPORTS: No. 101-516 (Comm. on Appropriations).

CONGRESSIONAL RECORD, Vol. 136 (1990):

July 19, considered and passed House.

Oct. 12, considered and passed Senate, amended.

Oct. 22, House agreed to conference report; receded and concurred in certain Senate amendments, in others with amendments.

Oct. 25, Senate agreed to conference report; concurred in certain House amendments, in others with amendments.

Oct. 26, House concurred in certain Senate amendment and disagreed to certain others. Senate receded from its amendments.

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATION BILL, 1991

JULY 12, 1990.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. NATCHER, from the Committee on Appropriations,
submitted the following

REPORT

[To accompany H.R. 5257]

The Committee on Appropriations submits the following report in explanation of the accompanying bill making appropriations for the Departments of Labor, Health and Human Services (except the Food and Drug Administration, Indian Health Service, and the Office of Consumer Affairs), and Education (except Indian Education), Action, the Corporation for Public Broadcasting, the Federal Mediation and Conciliation Service, the Federal Mine Safety and Health Review Commission, the National Commission on Acquired Immune Deficiency Syndrome, the National Commission on Libraries and Information Science, the National Commission to Prevent Infant Mortality, the National Council on Disability, the National Labor Relations Board, the National Mediation Board, the Occupational Safety and Health Review Commission, the Prospective Payment Assessment Commission, the Physician Payment Review Commission, the Railroad Retirement Board, and the United States Institute of Peace for the fiscal year ending September 30, 1991, and for other purposes.

INDEX TO BILL AND REPORT

	Page number	
	Bill	Report
Title I—Department of Labor:		
Employment and Training Administration	2	8
Labor-Management Services	6	16
Pension Benefit Guaranty Corporation	7	17

	<i>Page number</i>	
	<i>Bill</i>	<i>Report</i>
Employment Standards Administration.....	7	17
Occupational Safety and Health Administration.....	10	20
Mine Safety and Health Administration.....	11	20
Bureau of Labor Statistics.....	12	21
Departmental Management.....	12	22
Assistant Secretary for Veterans Employment and Training.....	12	23
Office of the Inspector General.....	13	24
General Provisions.....	13	.....
Title II—Department of Health and Human Services:		
Health Resources and Services Administration.....	14	25
Centers for Disease Control.....	17	42
National Institutes of Health.....	18	50
Alcohol, Drug Abuse and Mental Health Administration.....	22	91
St. Elizabeths Hospital.....	22	101
Office of the Assistant Secretary for Health.....	23	101
Agency for Health Care Policy and Research.....	23	104
Health Care Financing Administration.....	24	106
Social Security Administration.....	26	109
Family Support Administration.....	29	113
Assistant Secretary for Human Development Services.....	30	115
Office of the Secretary.....	31	123
General Provisions.....	32	.....
Title III—Department of Education:		
Compensatory Education for the Disadvantaged.....	38	124
Impact Aid.....	38	128
School Improvement Programs.....	39	130
Bilingual and Immigrant Education.....	40	139
Education for the Handicapped.....	40	140
Rehabilitation Services and Handicapped Research.....	40	142
Special Institutions for the Handicapped.....	40	147
Vocational and Adult Education.....	41	149
Student Financial Assistance.....	42	151
Guaranteed Student Loans.....	43	154
Higher Education.....	43	155
Howard University.....	44	162
College Housing and Academic Assistance Loans.....	44	164
Education, Research, Statistics, and Improvement.....	45	165
Libraries.....	46	169
Departmental Management.....	46	172
Office for Civil Rights.....	46	172
Office of the Inspector General.....	46	173
General Provisions.....	46	.....
Title IV—Related Agencies:		
Action.....	49	173
Corporation for Public Broadcasting.....	49	175
Federal Mediation and Conciliation Service.....	50	176
Federal Mine Safety and Health Review Commission.....	50	176
National Commission on Acquired Immune Deficiency Syndrome.....	50	176
National Commission on Libraries and Information Science.....	51	177
National Commission to Prevent Infant Mortality.....	51	177
National Council on Disability.....	51	177
National Labor Relations Board.....	51	178
National Mediation Board.....	52	178
Occupational Safety and Health Review Commission.....	52	178
Physician Payment Review Commission.....	53	178
Prospective Payment Assessment Commission.....	53	179
Railroad Retirement Board.....	53	179
Soldier's and Airmen's Home.....	.....	181

	Page number	
	Bill	Report
United States Institute of Peace	55	181
Title V—General Provisions.....	55	.....
House of Representatives Reporting Requirements.....	.....	181

SUMMARY OF ESTIMATES AND APPROPRIATIONS

The following table compares on a summary basis the appropriation for fiscal year 1990, the budget estimate for fiscal year 1991, and the Committee recommendations for fiscal year 1991 in the accompanying bill. In addition to these amounts, consideration of \$5,505,028,000 of budget estimates for 1991 has been deferred because authorizations have not been enacted for these programs. New budget authority provided in 1990 for these deferred items totals \$5,887,847,000.

A large portion (74.3%) of the appropriations in the bill is for entitlement programs in which funding levels are determined by the basic authorizing legislation. The bill includes \$126,567,563,000 for these entitlements in fiscal year 1991, an increase of \$1,033,736,000 over the amount requested by the President and an increase of \$12,371,172,000 above the amounts available for these programs in fiscal year 1990. For discretionary programs, in which spending is controlled through the annual appropriations bill, the bill includes \$43,875,436,000 in fiscal year 1991, an increase of \$3,178,442,000 over the President's budget and an increase of \$4,937,574,000 over the amount available for fiscal year 1990.

[In thousands of dollars]

	Fiscal year—			Fiscal year 1991 bill compared to—	
	1990 comparable	1991 budget	1991 bill	1990 comparable	1991 budget
Department of Labor	\$6,599,016	\$7,195,325	\$7,648,593	+\$1,049,577	+\$453,268
Department of Health and Human Services:					
Public Health Service:					
Health Resources and Services Administration	1,801,418	1,640,079	1,865,875	+ 64,457	+ 225,796
Centers for Disease Control	879,195	962,411	997,701	+ 118,506	+ 35,290
National Institutes of Health	7,276,783	7,623,175	8,317,654	+ 1,040,871	+ 694,479
Alcohol, Drug Abuse and Mental Health Administration	2,591,647	2,775,152	2,660,748	+ 69,101	- 114,404
Assistant Secretary for Health	156,405	175,550	179,386	+ 22,981	+ 3,836
Health Care Policy and Research	49,768	39,126	68,579	+ 18,811	+ 29,453
Subtotal, Public Health Service	12,755,216	13,215,493	14,089,943	+ 1,334,727	+ 874,450
Health Care Financing Administration	78,073,484	84,047,588	84,175,932	+ 6,102,448	+ 128,344
Social Security Administration	13,581,979	16,424,633	16,427,633	+ 2,845,654	+ 3,000
Family Support Administration	12,540,063	14,034,446	14,037,446	+ 1,497,383	+ 3,000
Human Development Services	5,408,027	6,599,384	6,855,409	+ 1,447,382	+ 256,025
Departmental Management	152,199	155,452	162,502	+ 10,303	+ 7,050
Total, HHS	122,510,968	134,476,996	135,748,865	+ 13,237,897	+ 1,271,869
Current year	105,164,480	115,023,996	116,295,865	+ 11,131,385	+ 1,271,869
Advances	17,346,488	19,453,000	19,453,000	+ 2,106,521	+ 0
Department of Education	23,012,014	23,549,441	26,027,751	+ 3,015,737	+ 2,478,310
Related Agencies	1,012,255	1,009,059	1,017,790	+ 5,535	+ 8,731
Grand total	153,134,253	166,230,821	170,442,999	+ 17,308,746	+ 4,212,178

[In thousands of dollars]

	Fiscal year—			Fiscal year 1991 bill compared to—	
	1990 comparable	1991 budget	1991 bill	1990 comparable	1991 budget
Mandatory	114,196,391	125,533,827	126,567,563	+ 12,371,172	+ 1,033,736
Discretionary	38,937,862	40,696,994	43,875,436	+ 4,937,574	+ 3,178,442
Unauthorized	5,887,847	5,505,028	(¹)	(¹)	(¹)
Current year total using 302(b) scorekeeping	150,535,376	163,570,971	167,783,149	+ 17,247,773	+ 4,212,178
Mandatory	112,271,391	122,852,827	123,886,563	+ 11,615,172	+ 1,033,736
Discretionary	38,263,985	40,718,144	43,896,586	+ 5,632,601	+ 3,178,442

¹ Deferred consideration.

TOTAL APPROPRIATIONS FOR LABOR, HEALTH AND HUMAN SERVICES AND EDUCATION PROGRAMS

In addition to the amounts included in the bill, very large sums are automatically appropriated each year for labor, health and human services, and education programs without consideration by the Congress during the annual appropriations process. The principal items in this category are the unemployment compensation, social security, medicare, and railroad retirement trust funds. The detailed estimates for the trust fund and permanent appropriations are reflected in a table appearing in the back of this report. In the aggregate, total budget authority for labor, health and human services, and education programs considered in this bill would increase from \$574,151,560,000 in 1990 to \$677,774,733,000 in 1991, an increase of \$103,623,173,000. These elements are displayed in the following table:

[In thousands of dollars]

	Fiscal year—		
	1990	1991	Change
Annual appropriation bill	\$153,134,253	\$170,442,999	+ \$17,308,746
Trust funds and permanent appropriations	456,584,942	545,179,634	+ 88,594,692
Deduct interfund payments	- 35,567,635	- 37,847,900	- 2,280,265
Total current action	574,151,560	677,774,733	+ 103,623,173
1990 appropriations for items not considered	5,887,847		

BUDGET REQUESTS NOT CONSIDERED

The Committee has deferred consideration of budget requests for some appropriations, as well as portions of requests for other appropriations, because authorizing legislation for fiscal year 1991 had not been enacted before the Committee reported the bill. The appropriation items deferred, together with the amounts requested for each and the comparable appropriations for 1990 are shown in the following table:

BUDGET REQUESTS NOT CONSIDERED

[In thousands of dollars]

	Comparable fiscal year 1990	Budget request
Department of Labor:		
Job training for the homeless	\$11,343	\$11,500
Targeted Jobs Tax Credit, trust funds	(24,653)	.....
Health Resources and Services Administration:		
Family planning	139,135	139,135
National Health Service Corps	50,719	51,243
Minority health initiative .....	.....	107,000
AIDS related drugs (AZT)	29,606	.....
Centers for Disease Control:		
Immunization	186,683	152,722
Tuberculosis grants	8,334	8,334
National Center for Health Statistics	47,077	48,128
National Institutes of Health research training and medical libraries assistance	299,569	304,814
Alcohol, Drug Abuse, and Mental Health Administration:		
Research training	31,347	34,138
Community support demonstrations	28,303	26,862
Office of Assistant Secretary for Health:		
Adolescent family life	9,421	9,431
Family Support Administration:		
Low income home energy assistance	1,443,000	1,050,000
Refugee and entrant assistance	374,822	368,822
Community services block grant	396,821	33,959
Human Development Services:		
Head Start	1,552,000	1,886,315
Child development associate scholarships	1,431	1,431
Dependent care planning and development	13,178	13,178
Developmental disabilities	98,477	98,477
School improvement, Follow through	7,171	.....
Education for the handicapped, special purpose	181,615	181,865
Vocational education	929,675	929,675
Soldiers' and Airmen's Home, trust funds	48,120	47,999
Total, unauthorized, deferred action	5,887,847	5,505,028

In addition to ongoing activities, the Committee has not provided funds at this time for a number of new programs which are currently being considered by the Congress. These programs include a large new child care initiative, a substantial expansion of Federal support for AIDS prevention and services activities, a minority health care initiative, and new breast and cervical cancer screening programs. The Committee has reserved \$2.9 billion of its section 302(b) allocation for expansion of deferred programs such as Head Start and for initial funding of new programs after they become law.

HIGHLIGHTS OF THE BILL

Bill total.—Appropriates \$170,443 million for the Departments of Labor, Health and Human Services and Education and Related Agencies. This is an increase of \$4,212 million over the President's request and an increase of \$17,309 million over fiscal year 1990. The bill is within its 302(b) ceilings for both budget authority and outlays.

Discretionary programs.—Allocates \$43,897 million for discretionary programs in fiscal year 1991, an increase of \$5,633 million over

comparable amounts currently available for fiscal year 1990. This is \$3,178 million more than requested by the President.

Mandatory programs.—Allocates \$123,887 million for entitlement programs in fiscal year 1991. Funding requirements for these activities are determined by the basic authorizing laws. This is an increase of \$11,615 million over the amounts currently available in fiscal year 1990 and an increase of \$1,034 million over the amount requested by the President. Mandatory programs include principally general funds support for the Medicare and Medicaid programs, Aid to Families with Dependent Children, Supplemental Security Income, Black Lung payments, Social Services Block Grants, and interest subsidy and default costs for Guaranteed Student loans.

Unauthorized activities.—Defers consideration of budget estimates totalling \$5,505 million for existing programs not yet authorized for fiscal year 1991. This includes funding for job training for the homeless, childhood immunizations, NIH research training, Head Start, low income energy assistance, refugee assistance, community services grants, family planning, handicapped education special purpose funds and vocational education. The Committee is holding funds in reserve under its 302(b) allocation for later funding of unauthorized programs. In addition to funding for existing programs, the Committee has reserved funds for new initiatives when these programs become authorized. When appropriations are made for these programs, the Committee will have fully utilized its 302(b) allocation.

Department of Labor.—Appropriates \$7,649 million for the Labor Department, an increase of \$1,050 million over fiscal year 1990 and an increase of \$453 million over the amounts requested by the President. This includes \$4,211 million to carry out the Job Training Partnership Act of which \$901 million is for Job Corps, an increase of \$98 million over fiscal year 1990, and \$514 million is for dislocated worker assistance, an increase of \$50 million over the 1990 level.

Department of Health and Human Services.—Appropriates \$135,749 million for the Department of Health and Human Services. This is an increase of \$13,238 million above 1990 and \$1,272 million above the President's request.

National Institutes of Health.—Appropriates \$8,318 million for biomedical research activities which are currently authorized at the National Institutes of Health. The Committee bill is \$694 million more than requested by the President and \$1,041 million over the comparable amount available in 1990. The Committee action provides for approximately 6,000 new grants in 1991. In addition the Committee has directed that funds be spent in the context of a new four year spending plan which includes cost management and cost control requirements.

Acquired Immune Deficiency Syndrome.—Provides approximately \$1.7 billion for research, education and other activities directed at the prevention and treatment of AIDS, which remains a critical health activity. This total includes funds provided by the Food and Drug Administration and the Indian Health Service. This is an increase of approximately 13 percent over the comparable amount expected to be spent on AIDS in 1990. The exact amount for AIDS-related biomedical research will be determined through the peer

review system as applied by the various institutes at the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. In addition to these amounts, the Committee expects to provide a substantial increase for AIDS prevention and services activities after the enactment of authorizing legislation which is currently in conference.

Substance abuse.—Appropriates \$2,613 million for various drug abuse programs within the Departments of Labor, Health and Human Services and Education. This is an increase of \$27 million over the amounts available in fiscal year 1990.

Homeless.—Appropriates \$102 million for currently authorized programs under the Stewart B. McKinney Act. This amount, together with \$29 million of advance funding, will provide an increase of \$30 million over the comparable 1990 appropriation level.

Low Income Health Programs.—Provides \$490 million for Community Health Centers, an increase of \$33 million over 1990; and \$599 million for Maternal and Child Health Block Grants, an increase of \$45 million over 1990.

Medicaid.—Provides \$45,015 million for Grants to States for Medicaid for fiscal year 1991, an increase of \$4,785 million above 1990.

Supplemental Security Income.—Provides \$15,159 million for monthly cash benefits to the needy aged, blind and disabled for 1991, an increase of \$2,864 million over the 1990 program level.

Social Security Administration, administrative costs.—Provides authority to spend \$4,167 million of Social Security trust funds for administrative costs. This is a \$330 million increase over 1990 and the same level as requested by the President. The Committee report directs SSA to reallocate funds so that staffing may be increased by 1,500 positions above the level proposed in the Budget.

Family Support Payments to States.—Provides \$12,657 million for grants to States for Aid to Families with Dependent Children and Child Support Enforcement activities for fiscal year 1991, an increase of \$965 million above 1990.

Department of Education.—Provides \$26,028 million for currently authorized programs at the Department of Education. This is an increase of \$3,016 million over 1990 and \$2,478 million over the President's request. These comparisons do not reflect increased amounts for deferred programs which will be provided after enactment of the reauthorizations.

Compensatory Education for the Disadvantaged.—Appropriates \$6,215 million for chapter 1 grants, an increase of \$1,003 million over 1990. The Committee has given this program its highest priority in allocating funds for fiscal year 1991.

Merit Schools.—Allows the President to transfer \$100 million to a new Merit Schools program from the Chapter 1 increase if this program becomes authorized.

Impact Aid.—Appropriates \$800 million for the Impact Aid program. This is an increase of \$139 million over the budget request and \$68 million over 1990. This includes \$140 million for category "b" payments which the President proposed to fund at \$25 million.

Education for the Handicapped.—Provides \$2,748 million for handicapped education state grants, an increase of \$728 million over 1990 and \$646 million over the President. This will increase

the federal share of the excess cost of educating a handicapped child from 7% to approximately 10%. In approving this increase the Committee has consolidated support for handicapped activities previously funded under Chapter 1 with the regular handicapped account.

Adult Education.—Provides \$244 million for adult education, an increase of \$51 million over 1990.

Student Aid.—Appropriates \$6,777 million for student financial assistance. This is an increase of \$692 million over 1990 funding and \$425 million above the amount requested by the President. This amount restores \$160 million to Perkins loans and \$60 million to state student scholarships, both of which the President proposed to eliminate. The Committee bill maintains the maximum Pell grant at \$2,300.

Related Agencies.—Provides \$1,018 million for the 16 related agencies funded in the bill. This includes \$307 million for the Corporation for Public Broadcasting for fiscal year 1993, of which \$47 million is for replacement of its satellite.

TITLE I—DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

PROGRAM ADMINISTRATION

The bill includes \$70,030,000 in general funds, an increase of \$3,550,000 over the budget request and \$5,401,000 more than the comparable FY 1990 amount. In addition, the bill includes authority to expend \$54,751,000 from the Employment Security Administration Account of the Unemployment Trust Fund, an increase of \$450,000 over the budget request and \$1,637,000 more than the comparable FY 1990 amount. The total funding included for this account, \$124,781,000, is \$4,000,000 over the request and is \$7,038,000 more than the comparable FY 1990 amount.

General funds in this account provide the Federal staff to administer employment and training programs under the Job Training Partnership Act, the Older Americans Act, the Trade Act and the National Apprenticeship Act. Trust funds provide for the Federal administration of employment security functions under Title III of the Social Security Act and the Immigration and Nationality Act, as amended by the Immigration Control and Reform Act. Federal staff costs related to the Wagner-Peyser Act in this account are split, 97 percent to three percent respectively, between unemployment trust funds and general revenues.

The Committee has funded 1,743 full-time equivalent (FTE) staff, an increase of 50 over the request and 18 over the comparable FY 1990 FTE level. The Committee believes that Federal monitoring and oversight of JTPA programs at the State and local levels must be increased and technical assistance efforts expanded. The budget request included further reductions in that capability at a time when significant changes are being proposed in the JTPA system. Accordingly, the Committee has provided \$3,000,000 over the request to finance the additional staff required.

The Committee recommendation provides for built-in increases for pay, promotions, Federal workers' compensation, personnel ben-

persons aged 55 or older in training programs. Service delivery areas should continue to utilize State and area agencies on aging and increase their involvement in job training programs.

FEDERAL UNEMPLOYMENT BENEFITS AND ALLOWANCES

The bill includes \$230,500,000, the amount of the budget request and \$49,524,000 less than the comparable 1990 amount. The 1991 amount for this account provides funding for three activities. The first, Trade Adjustment Assistance Benefits, provides special unemployment benefit payments to workers as authorized by the Trade Act of 1974, as amended. For this activity the Committee recommends \$159,000,000, the amount of the budget request, which will allow approximately 27,600 workers to receive approximately 804,100 weeks of trade adjustment assistance benefits at an average weekly amount of \$197.00.

The second activity, Trade Adjustment Assistance Training, provides for training, job search, and job relocation allowances to workers adversely affected by imports. The funding for this activity is authorized under the Trade Act of 1974, as amended by the Omnibus Trade and Competitiveness Act of 1988. For this activity, the Committee recommends \$71,000,000, the amount of the budget request, to provide services to an estimated 21,800 workers, of whom 17,500 will be enrolled in classroom training, 1,800 will receive on-the-job training, and 2,500 will receive job search and job relocation allowances.

The third activity, Unemployment Assistance and Payments under other Federal Unemployment Programs, currently provides for benefits authorized under the Redwood National Park Expansion Act amendments of 1978. These benefits include layoff, severance and vacation replacement, and entitlement to health, welfare and pension benefits for individuals deemed to be deprived of employment. The Committee recommends \$500,000 for this activity, the amount of the budget request, for these workers, to cover the costs of health and pension benefits.

STATE UNEMPLOYMENT INSURANCE AND EMPLOYMENT SERVICE OPERATIONS

The bill includes \$2,826,000,000, an increase of \$126,600,000 over the budget request, and, in addition, there is available the amount of \$12,500,000 appropriated in 1990 for obligation in 1991, providing a total availability of \$2,838,500,000. This total is \$214,387,000 over the comparable amount provided for 1990. The total includes an appropriation from general funds of \$25,600,000, together with an authorization to spend \$2,812,900,000 from the Employment Security Administration Account of the Unemployment Trust Fund including the amount appropriated in 1990 for 1991. The funds in this account are used to pay the administrative costs of the unemployment insurance and employment service activities in the State Employment Security Agencies.

For unemployment insurance services, the bill provides \$1,952,100,000 including contingency amounts, an increase of \$21,700,000 over the budget request, which is to be expended from the Employment Security Account of the Unemployment Trust

Fund. This amount is \$151,025,000 more than the comparable amount provided for 1990. The Committee recommendation for 1991 will support an estimated 42,262 State staff years, including 37,718 permanent staff. Funds have been added to the request to support an additional 1,243 permanent staff because the Committee believes that the workload justifies it. Temporary staff have been reduced by 1,003 to offset part of the cost of increasing the permanent staff. Sufficient permanent staff are provided to process 1.8 million claims per week. In addition, the Committee has again included an amount, \$18,882,000, to upgrade State unemployment insurance automated systems for benefit payment and tax collection purposes.

The Committee recommendation for unemployment insurance provides for built-in increases to allow for inflation, increased State salary, compensation and non-personnel costs, and to cover the normal expansion of the workforce.

Program changes of \$27,793,000 for unemployment insurance services consist of increases for the interstate communications satellite network, for alien eligibility verification, and for integrity activities covering the Eligibility Review and Benefit Payment Control Programs.

For the Employment Service, the bill provides \$873,900,000, an increase of \$104,900,000 over the budget request. In addition, \$12,500,000 was appropriated for Employment Service automation in 1990, for obligation in 1991, providing for a total availability of \$886,400,000 in 1991. This 1991 total is an increase of \$63,362,000 over the comparable 1990 amount.

Of the total 1991 amount, \$25,600,000 is provided from the general fund and the balance of \$860,800,000 is available from the Employment Security Administration Account of the Unemployment Trust Fund.

Included in the Employment Service amount is \$825,000,000 for State grants, for the program year July 1, 1991 through June 30, 1992, an increase of \$102,400,000 over the budget request and \$45,961,000 more than the comparable 1990 program year. This provides a six percent increase over 1990. Based on the history of Employment Service staff reductions and office closings, the Committee is opposed to any further reduction in the program. Of particular concern are any proposed closings of small local service points in rural areas of the country. Reports received by the Committee raise the question of fairness in some States. These closings would force unemployed citizens to drive long distances to receive basic employment services. With the additional funds provided in this bill, there should be no necessity to close these offices and the Committee fully expects the Department and the States to maintain the operation of these offices.

The balance of the Employment Service recommendation, \$61,400,000, is for national activities and includes the \$12,500,000 provided in 1990 and available in 1991 for Employment Service automation. The national activities recommendation is \$2,500,000 over the budget request and \$17,401,000 more than the comparable amount for 1990.

The national activities recommendation provides for a built-in increase of \$1,724,000 for inflation, as well as requested program in-

creases of \$1,635,000 for alien certification and to upgrade the General Aptitude Test Battery (GATB), and the inclusion of the \$12,500,000 for automation. In addition, the Committee has provided \$2,500,000 for a demonstration project for the automation and integration of Employment Service and Unemployment Insurance activities in the States. It is the Committee's understanding that all States currently have automated UI systems while automated ES systems lag behind. Having ES and UI systems on the same data base would allow an individual to file for both at the same time. An individual filing the combined UI/ES form would be simultaneously applying for unemployment insurance benefits as the State helps conduct a job search. In many cases an individual could be matched with a job before ever having to go on UI. This is beneficial to employees, employers, State and Federal governments, as well as the general taxpaying public. Employment Service automation is far behind UI automation, and this project could demonstrate both the importance of a fully automated and integrated UI/ES program as well as the benefits of automating ES systems.

The Committee has deferred funding of the Targeted Jobs Tax Credit program without prejudice pending its reauthorization. The Committee has supported this program in the past and will continue to do so.

ADVANCES TO THE UNEMPLOYMENT TRUST FUND AND OTHER FUNDS

The bill includes \$328,000,000, the amount of the request and an increase of \$295,000,000 over the FY 1990 amount. The appropriation is available to provide advances to several accounts for purposes authorized under various Federal and State unemployment compensation laws and the black lung compensation program, whenever balances in such accounts prove insufficient. The bill anticipates that advances will only be required for the Black Lung Disability Trust Fund in 1991.

The FY 1991 funding recommended by the Committee for this account, along with \$33,000,000 available from the fund balance in this account from the 1990 appropriation, will provide a total of \$361,000,000 to allow adequate cash flow within the Black Lung Disability Trust Fund.

The separate appropriations provided by the Committee for all other accounts eligible to borrow from this account in FY 1991 are expected to be sufficient. Should the need arise, due to unanticipated changes in the economic situation, laws, or for other legitimate reasons, advances will be made to the needy accounts to the extent funds are available. Funds advanced to the Black Lung Disability Trust Fund are now repayable with interest to the general fund of the Treasury.

The year 1991 marks the resumption of the payment of interest by the Black Lung Disability Trust Fund (BLDTF). Interest payments were suspended for a five year period (1985-1990) by the Consolidated Omnibus Budget Reconciliation Act of 1985. This moratorium expires in FY 1991 and the estimated interest payments by the BLDTF to the general fund of the Treasury total \$328,000,000.

the health professions and nursing loan revolving funds available for the HEAL program insurance fund. The Committee intends that \$10,000,000 of these funds be made available, and that they be used to offset costs in the health professions training programs rather than HEAL.

Maternal and child health and resources development

Maternal and child health (MCH) block grant

The bill includes \$598,627,000 for the Maternal and Child Health Block Grant. This is \$45,000,000 above the amount appropriated in fiscal year 1990 and \$20,000,000 above the amount requested by the President. The block grant provides funds to States to meet a broad range of health services, including preventive and primary care services for children and services for children with special health care needs. The authorizing statute provides that, up to a funding level of \$600 million, 85 percent of the funds be distributed to the States, while 15 percent of the funds are to be set aside by the Secretary for special projects of regional and national significance (SPRANS) in the categories of research, training, genetic diseases, hemophilia and infant mortality. The Committee has not included bill language requested by the Administration to provide \$25 million exclusively for a one-stop shopping initiative, since it would override the authorizing statute. The Committee expects, however, that some of the funding available for new SPRANS grants in 1991 will be used for this purpose.

The Committee is aware that five of the university affiliated programs receiving funding under the SPRANS setaside sustained significant funding reductions in fiscal year 1982. The Committee intends that \$1.4 million of the SPRANS setaside from 1991 funds be used to increase funding for these programs.

The Committee is concerned that the nation's infant mortality rate continues to be among the highest of the world's developed nations, and is particularly concerned with the increasing number of drug-addicted babies being born. Furthermore, there is a significant gap in the availability and level of care among different income groups. Accordingly, the Committee has provided an increase for the Maternal and Child Health block grant of \$45 million over 1990. At a time of increasing strain on Federal resources, the Committee notes that community support for infant mortality efforts is commendable. To the extent possible, the Committee encourages the Secretary to give priority to applications for SPRANS funding that include strong private sector and local support.

Pediatric emergency care

The Committee has not provided additional funding for emergency medical services for children for fiscal year 1991. The Administration did not request funding for this program; \$3,947,000 was appropriated in 1990. Since 1986, \$12.8 million has been provided to support demonstration projects for the effective delivery of emergency medical services to acutely ill and seriously injured children. Such projects can continue to be funded under the Maternal and Child Health block grant set-aside.

HEALTH CARE FINANCING ADMINISTRATION

GRANTS TO STATES FOR MEDICAID

The bill includes \$45,014,966,000 for the mandatory Federal share of State Medicaid costs in fiscal year 1991. This amount includes \$10,400,000,000 which was advance funded in the 1990 appropriation. In addition, the bill provides an advance appropriation of \$12,400,000,000 for program costs in the first quarter of fiscal year 1992. The bill also includes indefinite budget authority for unanticipated costs in 1991.

The amount recommended in the bill for fiscal year 1991 is \$113,457,000 above the amount requested by the President and \$4,785,464,000 over the comparable amount appropriated for fiscal year 1990. The Committee has rejected proposed bill language prohibiting the use of Medicaid funds for survey and certification activities. Such a proposal would require a change in the authorizing statute to permit user fees to be assessed for these activities.

Federal Medicaid grants reimburse States for 50 to 83 percent (depending on per capita income) of their expenditures in providing health care for individuals whose income and assets fall below specified levels. States have broad authority within the law to set eligibility, coverage and payment levels. It is estimated that nearly 26.2 million low income individuals will receive health care services in 1991 under the Medicaid program.

PAYMENTS TO HEALTH CARE TRUST FUNDS

The bill includes \$37,056,000,000 for the Payments to the Health Care Trust Funds account. This is an increase of \$717,500,000 above the 1990 level and is the same as the amount requested by the President under current law. This entitlement account includes the general fund subsidy to the Medicare Part B trust fund as well as other reimbursements to the Part A trust fund for benefits and related administrative costs which have not been financed by payroll taxes or premium contributions. \$36,451,000,000 of the amount recommended is for the Part B subsidy, which currently supports 75 percent of this program's costs.

The Committee calls to the attention of the Secretary the recent General Accounting Office report entitled, "Rural Hospitals: Federal Leadership and Targeted Programs Needed." This report identifies as one of several problems faced by rural hospitals their competitive disadvantage because they do not have the volume of services to purchase supplies in bulk or to negotiate favorable prices in procuring equipment or maintenance contracts. The Committee urges the Secretary to take whatever steps are appropriate to encourage the development of group purchasing arrangements among hospitals in rural areas or to take other actions which will maintain hospital services in rural areas.

PROGRAM MANAGEMENT

The bill includes \$104,966,000 in general funds and \$2,026,638,000 in trust funds for Federal administration of the Medicare and Medicaid programs. This is \$186,190,000 more than the comparable

amount available for this purpose for fiscal year 1990 and \$227,554,000 above the Administration request.

Research, demonstration, and evaluation

The bill includes \$69,000,000 for research and demonstrations, with \$13,000,000 of this amount supported by general funds and \$56,000,000 provided from trust funds. This total is \$33,000,000 above the amount requested by the Administration and \$19,000,000 above the comparable amount provided in 1990. These funds support a variety of studies and demonstrations in such areas as measurement of quality of care, refinement of the Medicare hospital prospective payment system and physician payments, long-term care, and utilization of medical services.

The bill includes \$23,000,000 for the rural hospital transition grant program. These grants assist rural hospitals that are experiencing severe financial difficulties, in part because of changes in the Medicare program such as the prospective payment system. Hospitals use these grants to plan and implement changes in the type of services they provide in order to remain fiscally viable. The funds provided will support the second year costs of grants made in 1990 and the third year costs of grants made in 1989, as well as about 100 new grants.

The bill also includes \$10,000,000 for the essential access community hospitals/rural primary care hospitals program which was authorized in the 1989 Reconciliation Act. No funding was requested for this program by the Administration. The program will provide grants to States to plan and implement rural health care networks and grants to hospitals to finance the costs of converting to essential access or rural primary care hospitals.

The Committee has not included bill language proposed by the Administration to clarify that this appropriation is to be the sole source of funding for the administrative costs of agency research projects, unless specifically authorized elsewhere. The Committee does, however, support this concept in its general application.

Medicare contractors

The bill provides \$1,583,000,000 to support Medicare claims processing contracts. This is the same as the amount requested by the Administration and an increase of \$128,986,000 over the amount of funds provided in fiscal year 1990. \$136,500,000 of this amount has been placed in a contingency reserve for unexpected operating costs, compared to the Administration request of \$173,000,000.

The Medicare program is administered largely by contractors who are responsible for paying Medicare beneficiaries and providers in a timely and fiscally responsible manner. In addition to processing claims, these contractors are also responsible for identifying and recovering Medicare overpayments, as well as reviewing claims for questionable utilization patterns and medical necessity. In addition, contractors provide information and technical support both to providers and beneficiaries regarding the administration of the Medicare program.

The Administration proposes an unusually large contingency fund, of which \$36.5 million is projected to be outlayed. The Committee has transferred the \$36,500,000 into operating expenses

from the contingency fund so that the funding will be available to the agency without further administrative action. This reduces funds in the contingency to historical levels consistent with truly unanticipated costs. The Committee has modified the bill language regarding the use of the contingency fund to make clear that it may be released for any unanticipated costs, such as increases in claims volume or postage costs.

State survey and certification

The bill includes \$163,436,000 for State inspection of nursing homes and other facilities serving Medicare beneficiaries. This is \$65,753,000 above the total available for this purpose in 1990. Of this amount, \$8,336,000 is provided from general funds and \$155,100,000 is from trust funds. An additional \$113.5 million is provided for this function in the Medicaid program account.

The purpose of this activity is to ensure that institutions and agencies providing care to Medicare patients meet acceptable standards of quality and safety. The Committee has increased funding above the 1990 level so that new legislative review requirements can be met.

The Committee has not accepted the Administration's proposal to eliminate Federal funding for survey and certification activities and convert the system to a user fee-financed operation. This would require a major change to authorizing legislation which is beyond the jurisdiction of this Committee. Accordingly, the Committee rejects the President's proposal to create a revolving fund for survey and certification user fees. The Committee does assume, however, the implementation of user fees for certification of clinical laboratories, as required under section 353 of the Public Health Service Act, and provides bill language making these user fees available within the Program Management account until expended.

Federal administration

The bill includes \$316,168,000 to support Federal administrative activities related to the Medicare and Medicaid programs. This is \$31,118,000 above the Administration request and a decrease of \$27,549,000 below the amount available in 1990. \$83,630,000 of this amount is provided from general funds and \$232,538,000 is supported by trust funds. This appropriation will support 4,127 full-time equivalent positions, the same number as requested by the Administration and 110 above the 1990 level. 100 of these positions will be financed by clinical laboratory certification fees. 170 full-time equivalents are added for expanded survey and certification activities, 65 full-time equivalents are added for implementation of the 1989 Reconciliation Act, and the total is reduced by 125 full-time equivalents no longer required for implementation of catastrophic health insurance. The amount provided for Federal administration assumes savings from the clinical laboratory user fees collected under current law, but not the \$31,118,000 in savings associated with the Administration's proposed law user fees.

HEALTH MAINTENANCE ORGANIZATION LOAN AND LOAN GUARANTEE FUND

The Committee does not provide funding for costs associated with the Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund. This amount is the same as the Administration request, and \$4,930,000 less than the 1990 appropriation.

The Fund was established in 1975 to provide working capital during the initial operating period of an HMO, when financial deficits were expected. Direct loans were made to HMOs from the Fund and, as made, were sold, with a guarantee, to the Federal Financing Bank. The Fund also guaranteed the repayments of loans made by private lenders to HMOs. The last loan commitments were made in 1983, and, by law, none can be made after 1986.

HCFA does not anticipate the need for an appropriation until 1993 to repay the Federal Financing Bank for accrued prepayment penalties and interest payments.

SOCIAL SECURITY ADMINISTRATION

PAYMENTS TO SOCIAL SECURITY TRUST FUNDS

The bill includes \$46,958,000 for mandatory payments necessary to compensate the Social Security system for cash benefits paid out, but for which no payroll tax is received. This is the same amount requested in the budget and a decrease of \$145,010,000 from the amount available in FY 1990. These funds reimburse the Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds for special payments to certain uninsured persons, costs incurred administering pension reform activities, and interest lost on the value of benefit checks issued but not negotiated. This appropriation restores the trust funds to the position they would have been in had they not borne these costs, properly charged to the general funds.

The amount provided includes \$25,458,000 for the cost of special payments to certain uninsured persons. These individuals, a declining population, attained retirement age before they could accumulate sufficient wage credits to qualify for benefits under the normal retirement formulas. Also included in this account is \$1,500,000 for reimbursements to the trust funds for administrative costs incurred in providing private pension plan information to individuals, and \$20,000,000 to reimburse the trust funds for the value of the interest for benefit checks issued but not negotiated.

The fiscal year 1991 appropriation decrease reflects the implementation of Public Law 100-86 which credits the value of unnegotiated checks directly to the trust funds from Treasury's general fund. Interest lost to the trust funds on unnegotiated checks continues to be funded through this appropriation.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

The bill includes \$841,081,000 for special benefits for disabled coal miners in FY 1991, including \$215,000,000 advance funded in FY 1990. This is the same amount requested in the budget and \$29,172,000 less than the current estimate for FY 1990.

This appropriation provides for cash benefits to miners who are disabled because of black lung disease, and to widows and children of miners. The Social Security Administration was responsible for taking, processing, and paying claims for miners' benefits filed from December 30, 1969 through June 30, 1973. Since that time it has continued to take claims, but forwards most of them to the Department of Labor for adjudication and payment. The Social Security Administration retains jurisdiction for some new claims for survivors of miners and will continue to pay benefits and maintain the beneficiary roll for the lifetime of all persons who filed during its jurisdiction. During FY 1991, there are expected to be about 205,000 miners, widows, and dependents who will be receiving monthly benefits which are paid by the Social Security Administration from this appropriation. The basic black lung benefit is 37½ percent of the amount paid to Federal employees in step 1 of grade GS-2. In addition to funds for FY 1991, the bill also includes an advance appropriation of \$203,000,000 for the first quarter of FY 1992.

SUPPLEMENTAL SECURITY INCOME PROGRAM

The bill provides \$15,158,594,000 for FY 1991 for the Supplemental Security Income program including \$3,157,000,000 advance funded in FY 1990. This is \$3,000,000 above the request, and \$2,863,836,000 more than the comparable estimate of \$12,294,758,000 for FY 1990.

These funds are used to pay Federal cash benefits to approximately 4.3 million aged, blind, and disabled persons with little or no income. The maximum monthly Federal benefit payable in FY 1991 under present law is estimated to be \$401 for an individual and \$601 for an eligible couple. In addition to federal benefits, the Social Security Administration administers a program of supplementary State benefits for those States which choose to participate.

The funds are also used to reimburse the trust funds for the administrative costs of the program with a final settlement by the end of the subsequent year required by law, support the referral and monitoring of certain disabled SSI recipients who are drug addicts or alcoholics and to reimburse State vocational rehabilitation services for successful rehabilitation of SSI recipients.

The appropriation increases in 1991 to reflect 12 monthly benefit payments in 1991 as compared to 11 in 1990. Additionally, there is a one-time increase in budget authority related to a change in the procedure for accounting for overpayments. Overpayment collections will no longer be used to offset costs to this appropriation but will be deposited into the treasury.

The bill includes \$5,275,000 for research and demonstration activities which is \$3,000,000 more than the President's request and the same as the 1990 appropriation. The increased funds are to be used to continue a program initiated in 1990 to provide outreach to potential SSI recipients, particularly the elderly. This population is often in need of cash assistance but does not apply for benefits both because of the stigma attached to government aid but also because of a lack of knowledge about eligibility. The Committee expects these funds to be targeted to economically disadvantaged popula-

tions with high levels of non-participation in the SSI program, and in areas of limited accessibility due to rural location or language barriers. These demonstrations should continue to use a combination of direct services along with grants and cooperative agreements with organizations such as the existing network of area agencies on aging. The Committee believes that these agencies can be a valuable resource in this effort. The Commissioner should consider the activities described under section 155 of the Older Americans Act in carrying out the program. The Committee encourages the Commissioner to determine the outreach approaches most effective in addressing the barriers to participation by potential SSI eligible individuals.

In addition to the funds for FY 1991 the bill also includes an advance appropriation of \$3,550,000,000 for the first quarter of FY 1992.

Zebley cases

The Supreme Court recently ruled in *Sullivan v. Zebley* that there must be a functional assessment of each child who applies for SSI disability benefits before the Social Security Administration can deny a child's claim. This invalidated the more stringent regulatory standards for childhood disability, under which children had to have impairments that either met the severity criteria of specific listings of impairments, or that were medically equal to listed impairments. Pursuant to the Court's decision, the Social Security Administration is currently preparing new regulations for determining disability in children under the age of 18. When these regulations are complete, the Social Security Administration will redetermine previously denied disability claims. However, the lower court to which the Supreme Court remanded this case for further proceedings, has not issued a final ruling as to the retroactive date of original applications now eligible for redeterminations, as well as other issues having budget impacts. Consequently, at this time, the budgetary impact of the *Zebley* decision has not been determined, and the Committee has not provided additional funds to implement this new requirement. The Committee expects the Administration to submit a supplemental appropriation request for this purpose and to be notified at the earliest possible date after cost estimates for beneficiary payments and administrative expenses have been determined. Prior to enactment of a supplemental, the Committee would be willing to consider a reprogramming request to address any immediate shortfalls if they occur.

LIMITATION ON ADMINISTRATIVE EXPENSES

The bill includes authority to spend \$4,166,974,000 in FY 1991 from the Social Security trust funds for administrative expenses of the Social Security Administration. This is the amount requested in the budget and is an increase of \$329,585,000 over the comparable FY 1990 limitation amount of \$3,837,389,000.

These funds support approximately 63,625 FTEs, computer support, resources for State disability agencies which make initial and continuing disability determinations, and other administrative costs. About 42 million beneficiaries receive a Social Security or

Supplemental Security Income check each month and cash payments are expected to reach \$272.2 billion during FY 1991.

The year to year increase is primarily to fund the built-in costs of maintaining staffing, computers, telephones, facilities and related support services at current levels. These increases are driven by pay raises, within-grade increases and promotions, as well as increased costs for retirement benefits, health benefits, rent, postage, medical costs, printing and supplies.

The Committee remains concerned as to the staffing level at which the Social Security Administration is operating. The Commissioner testified that SSA employees are stretched very thin after a 6-year period of downsizing during which the staffing level was reduced by 17,000 FTE's or 21 percent, and overtime and student employment programs were reduced by 4,600 workyears. While the impact of this reduction has largely been offset by a substantial investment in computerization and productivity improvements which have allowed service delivery, as measured by the Social Security Administration and General Accounting Office, to improve during this period, problems attributable to shortages of staff resources continue to exist. These problems, as evidenced in SSA's 1989 Onsite Process Review, include staffing imbalances across offices, poor morale, and high stress levels for employees struggling to keep up with their workload. While overall public satisfaction remains high, the consequences of these internal problems have been manifested in instances of diminished service to the public such as longer waiting times, a reduction in personal contacts outside the office, high busy signal rates for the 800 number telephone service and increasing post-entitlement case backlogs.

Additional funding made available to the Social Security Administration in 1990 from the contingency reserve has in part been applied toward increasing staff. The Social Security Administration expects to reach an annualized staffing level of 62,875 FTE by the end of 1990, which is the staffing level supported by the 1991 budget request. The Committee believes that additional positions are justified and expects SSA to reprogram up to \$25 million from funds provided in the bill to add an additional 1,500 positions in 1991 (+750 FTE assuming a six month lapse rate). This will produce a 1991 staffing level of approximately 63,625 FTE, and a 1992 annualized base of 64,375 FTE. Funds may be reprogrammed from within the base or from increases provided in 1991 for items such as new furniture, building services, office automation and systems integration services project.

Additionally, the Committee is aware of a report of the Inspector General which concluded that there are insufficient bilingual staff to meet the needs of non-English speaking clients, and the Committee encourages the Social Security Administration to increase the number of bilingual staff in the field offices.

The Social Security Administration's estimates of workyear requirements are built upon past workload experience of the time it took to process each unit of work, as revised by estimates of future workloads and management, procedural and automation improvements. These estimates do not reflect the time it *should* take to carry out a particular task. In order to determine appropriate staff resource requirements, the Committee encourages the Social Secu-

riety Administration to work with the General Accounting Office and report back to the Committee on the ability to develop a work force planning system using engineered time standards for its largest and most important workloads.

Individuals suffering from chronic fatigue syndrome (CFS) continue to encounter difficulties in applying for Social Security disability. The Committee directs the Social Security Administration to do everything necessary to facilitate a consistent national policy for resolving disability claims filed by persons apparently suffering from CFS. SSA is encouraged to ensure that claims are evaluated by staff who are fully informed of the latest medical information on CFS.

The Committee is aware of and supportive of plans by the Commissioner to provide access to hearings and appeals offices by designating new office locations in areas of the country which can improve services. This includes the decision made earlier this year by the Commissioner to establish a new office to serve areas of Northern Mississippi. The bill includes sufficient funds to fully support this initiative.

FAMILY SUPPORT ADMINISTRATION

The bill includes \$14,037,466,000 for programs administered by the Family Support Administration. These programs include Aid to Families with Dependent Children (AFDC), child support enforcement, Job Opportunities and Basic Skills (JOBS) Training, low income home energy assistance (LIHEAP), refugee and entrant assistance, community services activities and State legalization impact assistance grants (SLIAG). Funding has been deferred for the refugee program, LIHEAP, and community services activities which have not been reauthorized for fiscal year 1991.

FAMILY SUPPORT PAYMENTS TO STATES

The bill includes authority to spend \$12,657,246,000 during fiscal year 1991 for Family Support Payments to States. This is \$964,694,000 more than the comparable appropriation for 1990, and the same as the President's request. The fiscal year 1991 amount includes \$3,000,000,000 in advance funding that was provided in 1990. Consistent with historical practice, the Committee has also included \$3,300,000,000 for advance funding of the first quarter of fiscal year 1992, as well as indefinite appropriations authority to prevent any disruption in payments in fiscal year 1991.

This appropriation combines funding for the assistance payments and child support enforcement programs. The assistance payments programs are administered by State welfare agencies under individual plans developed by each State consistent with Federal requirements. The largest of the programs is AFDC, which provides basic cash benefits for needy children. The Federal government, on average, finances 55 percent of the cash benefits provided to AFDC households. The Child Support Enforcement program was created to locate absent parents, to enforce their support obligations, and to establish paternity. The Federal government provides 86 percent of the costs incurred by State and local governments in administering the program.

The amount provided includes \$489 million for child care expenses authorized by Title IV-A of the Social Security Act for participants in the JOBS program and transitional child care for up to 12 months for former AFDC recipients who have left the rolls due to increased income from employment. Of this amount, \$13 million is provided for the child care standards and licensure grants authorized in the Family Support Act of 1988.

PAYMENTS TO STATES FOR AFDC WORK PROGRAMS

The Committee provides \$1,000,000,000 for payments to States for AFDC work programs, which is the same as the Administration request. This is the second year of funding for the JOBS Training Program established under section 201 of the Family Support Act of 1988. JOBS programs must be operating in all States by the end of fiscal year 1990, at which time existing AFDC work programs and the WIN program will be repealed. State JOBS programs must include educational activities, including high school or equivalent education, basic and remedial education, and education for those with limited English proficiency. The programs must also provide job skills training, job readiness, and job development and placement, along with at least two of the following: group and individual job search, on-the-job training, work supplementation, and community work experience.

STATE LEGALIZATION IMPACT ASSISTANCE GRANTS

The Immigration Reform and Control Act of 1986 established a four-year program of State Legalization Impact Assistance Grants to offset costs incurred by State and local governments in providing certain public assistance, public health assistance and educational services to aliens legalized under that law. The Act appropriated, for each of fiscal years 1988 through 1991, \$1,000,000,000, minus the Federal cost of providing certain assistance programs to these aliens. As a result, annual appropriations action is not required.

The Administration requested bill language that would have reduced the automatic appropriation to States by \$537,403,000 in 1991, and also eliminated the amount which was provided as an advance appropriation for 1992 in the 1990 bill. The Committee has not approved this bill language.

PROGRAM ADMINISTRATION

The Committee includes \$81,200,000 for Program Administration. This is \$2,000,000 above the Administration request and \$4,253,000 below the comparable appropriation for 1990. This account provides resources for the Family Support Administration to administer the various programs under its jurisdiction, as well as to conduct research and evaluation studies.

The Committee provides for a staffing level of 1,029 full-time equivalent positions, which is the same level requested by the President.

The Committee rejects the Administration request to amend through bill language the Social Security Act to permit the Family Support Administration to collect fees from State and local governments which use the Federal Parent Locator Service on behalf of

AFDC clients. However, the Committee has included bill language which allows currently authorized Federal Parent Locator Service user fees which are charged on behalf of non-AFDC clients to be retained in the FSA program administration account, rather than being credited directly to the general fund of the treasury.

The Committee has also included bill language which extends the availability of funding appropriated in 1990 for the Interstate Child Support Commission through the end of fiscal year 1991.

The Committee has provided an additional \$2,000,000 for research and evaluations over the amount requested by the President. This will allow the initiation of studies and demonstrations that were authorized in the Family Support Act of 1988.

ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

SOCIAL SERVICES BLOCK GRANT

The bill includes \$2,800,000,000, the same as the budget request and the full amount authorized for fiscal year 1991. The 1990 appropriation was the same.

The social services block grant program is designed to encourage each State, as far as practicable, to furnish a variety of social services best suited to the needs of individuals residing within the State. Beginning with fiscal year 1982 the social services block grant replaced grants to States for social services, child day care, and State and local training.

Social services block grant funds are distributed to the territories in the same ratio such funds were allocated to territories in 1981. The remainder of the appropriation is distributed to the States and the District of Columbia according to relative State population.

HUMAN DEVELOPMENT SERVICES

The bill includes \$1,423,217,000, an increase of \$95,116,000 over the budget request considered and \$152,306,000 over the 1990 comparable appropriation.

The Committee has deferred consideration of appropriations for the Headstart program, child development associate scholarships, dependent care planning and development and the developmental disabilities program because authorizing legislation for them was not enacted when the Committee reported the bill.

Comprehensive child development centers

The Committee has included \$24,668,000 for the Comprehensive Child Development Program. This is the same as 1990 and is the amount requested in the budget. The purpose of this program is to provide financial assistance to projects on a multiyear basis, that

- (1) are designed to encourage intensive, comprehensive, integrated, and continuous supportive services for infants and young children from low-income families from birth until they reach public school age;

- (2) will enhance their physical, social, emotional, and intellectual development and provide support to their parents and other family members; and

to groups who are severely impacted by natural or man-made disasters, such as large oil spills.

Program direction

The Committee has approved \$75,000,000 for program direction expenses, an increase of \$3,851,000 over the budget request and \$6,687,000 over 1990. This amount will support 1,060 full-time equivalent positions and related expenses, an increase of 60 over the current level. The Committee has added 60 FTE's and additional funding to allow the agency to expand and improve its grant monitoring and oversight, particularly in the expanding Headstart program. This agency oversees a large number of categorical grant programs. It must have adequate staff and administrative funding to allow it to do a proper job of program oversight. The amount provided also accommodates various built-in cost increases, such as for Federal pay increases, merit pay, health benefits, travel and communications costs. The Committee admonishes the agency not to use funds appropriated for grant programs to pay for administrative expenses; these expenses should be paid for from this budget activity.

The Committee is aware that the authorizing committees are considering legislation authorizing a longitudinal study of Headstart as part of its reauthorization. The Committee agrees that such a study is needed and urges the Department to proceed with such an effort as expeditiously as possible.

PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE

The bill includes \$2,632,192,000, an increase of \$160,909,000 over the amount requested in the budget, and an increase of \$1,257,276,000 over the 1990 appropriation.

The amount includes \$2,421,712,000 for the Foster Care program, which provides maintenance payments for children who must live outside their homes. This is an increase of \$1,221,651,000 over the 1990 level, a large portion of which is for payment of prior-year claims. The 1991 amount reflects increased State claims and a large increase in the average monthly number of children in foster care (from 157,000 in 1989 to 203,000 in 1991). The amount for Foster Care includes \$544,000,000 to pay prior-year claims. There was no appropriation for prior-year claims in 1990. The appropriation for Foster Care recommended by the Committee is sufficient to fund estimated costs under current law. The Committee has not approved the Administration's request to include legislative bill language to place an arbitrary cap on State entitlements; this is clearly a matter for the authorizing committees to decide.

The total also includes \$150,480,000 for Adoption Assistance, which represents an increase of \$25,625,000 over the 1990 appropriation. This program provides an alternative to long, inappropriate stays in foster care by helping to develop permanent placements with caring families. In 1991, all States plus the District of Columbia are expected to use this program. The 1991 amount reflects increased State expenditures and continued growth in the number of children assisted to nearly 52,000.

The Committee has included \$60,000,000, the amount requested and \$10,000,000 over 1990, for the independent living program. This program provides services to foster children age 16 or older to help assist them make the transition to independent living by helping them earn a high school diploma or receive vocational training; receive training in daily living skills such as budgeting, locating housing, career planning and job finding; or otherwise make the transition to independent living. Funds are awarded to States in the form of grants. Each State is eligible to receive a proportion of the funds appropriated that is equal to the State's proportion of the national total of foster children receiving maintenance payments under the title IV-E Foster Care program.

OFFICE OF THE SECRETARY

GENERAL DEPARTMENTAL MANAGEMENT

The bill includes \$82,250,000 for general departmental management, an increase of \$900,000 over the budget request and an increase of \$2,834,000 over the comparable amount for 1990. Also included is authority to spend \$31,950,000 from the Social Security trust fund, an increase of \$850,000 over the budget request and over the authority granted in 1990.

This appropriation supports those activities that are associated with the Secretary's roles as policy officer and general manager of the Department. The Office of the Secretary also implements Administration and Congressional directives, and provides assistance, direction and coordination to the headquarters, regions and field organizations of the Department.

A total of 1,498 FTE's has been approved, including 760 for the General Counsel. The amount recommended includes built-in increases in personnel compensation and benefits and space rental. The Committee has added \$1,500,000 to the budget request to restore 25 FTE's that were deleted in the Office of General Counsel. The Department's legal workload justifies retaining the staff. In addition, \$250,000 has been added to continue the rural transportation technical assistance activity that was begun in 1990.

OFFICE OF THE INSPECTOR GENERAL

The bill includes \$53,500,000, an increase of \$2,000,000 over the budget request and an increase of \$3,012,000 over the 1990 amount. The Committee has also approved a trust fund transfer of \$43,723,000, the same as the budget request and the 1990 amount. A total of 1,437 FTE's is provided, the same as 1990.

The Office of the Inspector General was created by law in 1976 to protect the integrity of Departmental programs as well as the health and welfare of beneficiaries served by those programs. Through a comprehensive program of audits, investigations, inspections and program evaluations, the OIG reduces the incidence of fraud, waste, abuse and mismanagement, and promotes economy, efficiency and effectiveness throughout the Department.

The amount recommended includes built-in increases for personnel compensation and benefits and space rental.

ferred programs, the Committee expects to use all of its 302(b) allocation for 1991.

The bill provides no new spending authority as described in section 401(c)(2) of the Congressional Budget and Impoundment Control Act of 1974 (Public Law 93-344), as amended.

In accordance with section 308(a)(1)(C) of the Congressional Budget Act of 1974 (Public Law 93-344), as amended, the following information was provided to the Committee by the Congressional Budget Office:

FIVE-YEAR PROJECTIONS

In compliance with section 308(a)(1)(C) of the Congressional Budget Act of 1974 (Public Law 93-344), as amended, the following table contains five-year projections associated with the budget authority provided in the accompanying bill:

Budget authority.....	\$150,683,494,000
Outlays:	
Fiscal year 1991.....	124,990,287,000
Fiscal year 1992.....	26,496,568,000
Fiscal year 1993.....	5,636,747,000
Fiscal year 1994.....	746,329,000
Fiscal year 1995 and future years.....	8,284,000

FINANCIAL ASSISTANCE TO STATE AND LOCAL GOVERNMENTS

In accordance with section 308(a)(1)(D) of the Congressional Budget Act of 1974 (Public Law 93-344), as amended, the financial assistance to State and local government is as follows:

New budget authority.....	\$70,609,062,000
Fiscal year 1991 outlays resulting therefrom.....	55,026,914,000

TRANSFER OF FUNDS

Pursuant to Clause 1(b), Rule X of the House of Representatives, the following table is submitted describing the transfer of funds provided in the accompanying bill.

The table shows, by Department and agency, the appropriations affected by such transfers.

APPROPRIATION TRANSFERS RECOMMENDED IN THE BILL

Account to which transfer is to be made	Amount	Account from which transfer is to be made	Amount
Department of Labor:			
Employment Standards Administration:		U.S. Postal Service:	
Special Benefits.....	Indefinite	Postal Service fund.....	Indefinite
		Department of Labor:	
Salaries and expenses.....	\$29,051,000	Employment Standards Administration:	
Departmental management:		Black lung disability trust fund.....	\$29,051,000
Salaries and expenses.....	23,355,000	Black lung disability trust fund.....	23,355,000
Office of Inspector General.....	371,000	Black lung disability trust fund.....	371,000

CHANGES IN APPLICATION OF EXISTING LAW

Pursuant to clause 3, rule XXI of the House of Representatives, the following statements are submitted describing the effect of pro-

visions in the accompanying bill which may directly or indirectly change the application of existing law.

In some cases, the Committee has recommended appropriations which are less than the maximum amount authorized for the various programs which are funded in the bill. Whether these actions constitute a change in the application of existing laws is subject to individual interpretation, but the Committee felt that this fact should be mentioned.

The bill provides that appropriations shall remain available for more than one year for some programs for which the basic authorizing legislation does not presently authorize such extended availability.

In various places in the bill, the Committee has earmarked funds within appropriation accounts in order to fund specific sections of a law. Whether these actions constitute a change in the application of existing law is subject to individual interpretation, but the Committee felt that this fact should be mentioned.

On page 5 of the bill is language allowing the Labor Department to withhold from State allotments funds available for penalty mail under the Wagner-Peyser Act.

On page 10 is language establishing a maximum amount available for grants to States under the Occupational Safety and Health Act, which grants shall be no less than 50 percent of the costs of State programs required to be incurred under plans approved by the Secretary under section 18(b) of the Act.

On page 10 of the bill are two provisions that (1) exempt farms employing 10 or fewer people from the Occupational Safety and Health Act, except those farms having a temporary labor camp and (2) prohibit the promulgation or enforcement of any regulation under the Occupational Safety and Health Act which restricts work activity in any area by reason of the potential for recreational hunting, fishing, or sports shooting in the area.

On page 11 of the bill is language allowing the Secretary of Labor to use any funds available to the Department to provide for the costs of mine rescue and survival operations in the event of major disasters.

On page 11 of the bill is a proviso prohibiting the carrying out of sections 104(g)(1) or 115 of the Federal Mine Safety and Health Act with respect to shell dredging, or with respect to any sand, gravel, surface limestone, surface clay, or colloidal phosphate mine.

On page 15 of the bill is a provision that notwithstanding section 838 of the Public Health Service Act, not to exceed \$10,000,000 of funds returned to the Secretary pursuant to section 839(c) of the Public Health Service Act or pursuant to a loan agreement under section 740 or 835 of the Act may be used for activities under titles III, VII, and VIII of the Act.

On page 15 is language providing that user fees authorized by 31 U.S.C. 9701 may be credited to appropriations for the Health Resources and Services Administration, notwithstanding 31 U.S.C. 3302.

On page 18 is language providing that collections from user fees may be credited to the Centers for Disease Control appropriation.

On page 22 is language providing that funds available for block grants under subpart 1, part B of title XIX of the Public Health

Service Act shall be expended by States in accordance with the same criteria and limitations as were applied to such grants for the fiscal year 1990.

On page 25 of the bill is a provision that in the administration of title XIX of the Social Security Act, payments to a State for any quarter may be made with respect to a State plan or plan amendment in effect during any such quarter, if submitted in, or prior to, such quarter and approved in that or any such subsequent quarter.

On page 26 is language allowing fees charged in accordance with 31 U.S.C. 9701 and section 353 of the Public Health Service Act to be credited to the Health Care Financing Administration administrative account.

On page 26 is language providing that certain travel expense payments under the Federal Mine Safety and Health Act may be made only when travel of more than 75 miles is required.

On page 26 is language providing that monthly black lung benefits shall be rounded to the nearest dollar as is currently done with other benefits paid by the Social Security Administration.

On page 28 is language providing that travel expense payments under section 1631(h) of the Social Security Act may be made only when travel of more than 75 miles is required.

On page 28 is language requiring that none of the funds appropriated by this Act may be used for the manufacture, printing, or procuring of Social Security cards, as provided in section 205(c)(D) of the Social Security Act, where paper and other materials used in the manufacture of such cards are produced, manufactured, or assembled outside of the United States.

On page 30 is language allowing fees charged in accordance with section 453 of the Social Security Act to be credited to the Family Support Administration administrative account.

On page 38 is language providing that from the amounts appropriated for part A of chapter 1 of title I of the Elementary and Secondary Education Act, an amount not to exceed \$100,000,000 may be obligated to carry out a new Merit Schools program only if such program is specifically authorized in law prior to December 31, 1990.

On page 42 is language providing that the maximum Pell grant a student may receive in the 1991-92 academic year is \$2,300.

On page 42 is language providing that notwithstanding section 479A of the Higher Education Act of 1965 student financial aid administrators shall be authorized, on the basis of adequate documentation, to make necessary adjustments to the cost of attendance and expected student or parent contribution (or both) and to use supplementary information about the financial status or personal circumstances of eligible applicants only for purposes of selecting recipients and determining the amount of awards under subpart 2 of part A, and parts B, C, and E of title IV of the Act: *Provided further*, That notwithstanding section 411F(1) of the Higher Education Act of 1965 as amended, the term "annual adjusted family income" shall, under special circumstances prescribed by the Secretary, mean the sum received in the first calendar year of the award year from the sources described in that section.

On page 43 is language providing that funds provided herein for carrying out subpart 6 of part A of title IV shall be available not-

**COMPARATIVE STATEMENT OF NEW BUDGET (OBLIGATIONAL) AUTHORITY FOR 1990 AND THE
BUDGET ESTIMATES FOR 1991**

PERMANENT NEW BUDGET (OBLIGATIONAL) AUTHORITY

[These funds become available automatically under earlier, or "permanent" law without further, or annual action by the Congress. Thus, these amounts are not included in the accompanying bill.]

(1) Agency and item	(2) New budget (obligational) authority, fiscal year 1990	(3) Budget estimates of new (obligational) authority, fiscal year 1991	(4) Fiscal year 1991 estimate com- pared with, fiscal year 1990
FEDERAL FUNDS			
DEPARTMENT OF LABOR			
Panama Canal Commission Compensation Fund	12,100,000	12,600,000	+ 500,000
DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Health Resources and Service Administration: Health Resources and Services		11,885,000*	+ 11,885,000
National Institute of Health: Office of the Director	200,000	200,000	.....
Centers for Disease Control: Disease control, research, and training ...	255,000	346,000	+ 91,000
Alcohol, Drug Abuse, and Mental Health Administration:			
Alcohol, drug abuse, and mental health		7,359,000	+ 7,359,000
Health Care Financing Administration:			
Grants to States for Medicaid	9,000,000,000	10,400,000,000	+ 1,400,000,000
Payments to health care trust funds	367,000,000	-4,000,000	-371,000,000

Social Security Administration:					
Payments to Social Security trust funds.....	4,597,000,000	4,894,000,000			+ 297,000,000
Special benefits for disabled coal miners.....	211,000,000	215,000,000			+ 4,000,000
Supplemental security income program	2,936,000,000	3,157,000,000			+ 221,000,000
Family Support Administration:					
Family support payments to States.....	2,700,000,000	3,000,000,000			+ 300,000,000
Community services block grant		8,041,000			+ 8,041,000
Interim assistance to States for legalization	870,000,000	840,000,000			-30,000,000
Total, Department of Health and Human Services	20,681,455,000	22,529,831,000			+ 1,848,376,000
DEPARTMENT OF EDUCATION					
Vocational and adult education.....	7,148,000	7,148,000			
Guaranteed student loans.....	3,868,826,000	3,157,427,000			-711,399,000
Total, Department of Education	3,875,974,000	3,164,575,000			-711,399,000
CORPORATION FOR PUBLIC BROADCASTING					
Public broadcasting fund.....	232,648,000	298,870,000			+ 66,222,000
RAILROAD RETIREMENT BOARD					
Dual benefits payment account.....	157,000	1,000			-156,000
Federal Payments to Railroad Retirement Accounts.....	2,703,900,000	2,730,700,000			+ 26,800,000
Total, permanent new budget (obligational) authority, Federal funds.....	27,506,234,000	28,736,577,000			+ 1,230,343,000

COMPARATIVE STATEMENT OF NEW BUDGET (OBLIGATIONAL) AUTHORITY FOR 1990 AND THE BUDGET ESTIMATES FOR 1991--Continued

PERMANENT NEW BUDGET (OBLIGATIONAL) AUTHORITY

[These funds become available automatically under earlier, or "permanent" law without further, or annual action by the Congress. Thus, these amounts are not included in the accompanying bill.]

Agency and item (1)	New budget (obligational) authority, fiscal year 1990 (2)	Budget estimates of new (obligational) authority, fiscal year 1991 (3)	Fiscal year 1991 estimate com- pared with, fiscal year 1990 (4)
TRUST FUNDS			
DEPARTMENT OF LABOR			
Employment and Training Administration: Unemployment trust funds	26,200,000,000	25,400,000,000	-800,000,000
Special workers' compensation expenses	99,000,000	108,000,000	+ 9,000,000
Gifts and bequests, Secretary of Labor and National Commission for Employment Policy	10,000	10,000	.....
Total, Department of Labor	26,299,010,000	25,508,010,000	-791,000,000
DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Assistant Secretary for Health: Public Health Service trust funds	8,124,000	8,124,000	.....
Health Care Financing Administration:			
Federal hospital insurance trust fund	80,382,737,000	87,488,338,000	+ 7,105,601,000
Federal hospital insurance catastrophic coverage reserve fund	39,000,000	.....	-39,000,000
Federal supplementary medical insurance trust fund	46,179,000	49,530,000,000	+ 49,483,821,000
Federal supplementary medical insurance, catastrophic	382,900,000	.....	-382,900,000

Social Security Administration:			
Federal old-age survivors insurance trust fund 1/.....		311,039,958,000	+ 28,275,990,000
Federal disability insurance trust fund 1/.....		32,159,432,000	+ 3,509,391,000
Total, Department of Health and Human Services.....		480,225,852,000	+ 87,952,903,000
DEPARTMENT OF EDUCATION			
Departmental management: Contributions.....			
	1,000		-1,000
RAILROAD RETIREMENT BOARD			
Rail Industry Pension Fund.....	3,275,890,000	3,177,737,000	-98,153,000
Railroad Social Security Equivalent Benefit Account.....	7,117,101,000	7,420,335,000	+ 303,234,000
Supplemental Annuity Pension Fund.....	113,752,000	111,118,000	-2,634,000
Total, Railroad Retirement Board.....	10,506,743,000	10,709,190,000	+ 202,447,000
SOLDIERS' AND AIRMEN'S HOME			
Payment of claims.....			
	5,000	5,000	
Total, permanent new budget (obligational) authority, Trust funds.....	429,078,708,000	516,443,057,000	+ 87,364,349,000
Total, permanent new budget (obligational) authority, Federal funds and Trust funds.....	456,584,942,000	545,179,634,000	+ 88,594,692,000
1/ Included as "off-budget".			

COMPARATIVE STATEMENT OF NEW BUDGET (OBLIGATIONAL) AUTHORITY FOR 1990 AND BUDGET ESTIMATES AND AMOUNTS RECOMMENDED IN THE BILL FOR 1991

(1) Agency and item	(2) New budget (obligational) authority appropriated, 1990 (enacted to date)	(3) Budget estimates of new (obligational) authority, 1991	(4) New budget (obligational) authority recommended in bill	(5) Bill compared with new budget (obligational) authority, 1990	(6) Bill compared with budget estimates of new (obligational) authority, 1991
SUMMARY					
Title I - Department of Labor:					
Federal Funds					
Current year	6,599,016,000	7,195,325,000	7,648,593,000	+ 1,049,577,000	+ 453,268,000
1992 advance	(6,597,516,000)	(7,195,325,000)	(7,648,593,000)	(+ 1,051,077,000)	(+ 453,268,000)
1992 advance	(1,500,000)	.....	.....	(-1,500,000)	.....
Unauthorized, not considered by House	(11,343,000)	(11,500,000)	DEFER	DEFER	DEFER
Trust Funds	(2,941,886,000)	(3,016,439,000)	(3,156,566,000)	(+ 214,680,000)	(+ 140,127,000)
1991 advance	(12,500,000)	.....	.....	(-12,500,000)	.....
Unauthorized, not considered by House	(24,653,000)	.....	DEFER	DEFER	DEFER
Title II - Department of Health and Human Services:					
Federal Funds (all years)	122,510,968,000	134,476,996,000	135,748,865,000	+ 13,237,897,000	+ 1,271,869,000
Current year	(105,164,480,000)	(115,023,996,000)	(116,295,865,000)	(+ 11,131,385,000)	(+ 1,271,869,000)
1992 advance	(17,346,488,000)	(19,453,000,000)	(19,453,000,000)	(+ 2,106,512,000)	.....
Unauthorized, not considered by House	(4,709,923,000)	(4,333,989,000)	DEFER	DEFER	DEFER
Trust Funds	(5,767,111,000)	(6,088,805,000)	(6,279,322,000)	(+ 512,211,000)	(+ 190,517,000)

Total, Public Health Service:				
Federal Funds.....	12,755,216,000	14,089,943,000	+1,334,727,000	+874,450,000
Current year.....	(12,735,972,000)	(14,089,943,000)	(+1,353,971,000)	(+874,450,000)
Advance funding for FY 1991.....	(19,244,000)		(-19,244,000)	
Unauthorized, not considered by House.....	(830,194,000)			
Trust funds.....	(6,037,000)			
HEALTH CARE FINANCING ADMINISTRATION				
GRANTS TO STATES FOR MEDICAID 1/				
Medicaid current law benefits.....	38,214,759,000	42,868,526,000	+4,653,767,000	
State and local administration.....	2,014,743,000	2,146,440,000	+131,697,000	
Proposed legislation, user fees.....		-113,457,000		+113,457,000
Subtotal, Medicaid program level, FY 1991.....	40,229,502,000	45,014,966,000	+4,785,464,000	+113,457,000
Less funds advanced in prior year.....	-9,000,000,000	-10,400,000,000	-1,400,000,000	
Total, current request, FY 1991.....	31,229,502,000	34,614,966,000	+3,385,464,000	+113,457,000
New advance, 1st quarter, FY 1992.....	10,400,000,000	12,400,000,000	+2,000,000,000	
PAYMENTS TO HEALTH CARE TRUST FUNDS				
Supplemental medical insurance.....	35,925,500,000	36,451,000,000	+525,500,000	
Hospital insurance for uninsured.....	378,000,000	559,000,000	+181,000,000	
Federal uninsured payment.....	35,000,000	46,000,000	+11,000,000	
Total, Payment to Trust Funds 2/.....	36,338,500,000	37,056,000,000	+717,500,000	

1/ Excludes \$25,000,000 in legislative additions proposed for later transmittal.

2/ Excludes legislative savings of \$1,981 million proposed for later transmittal.

COMPARATIVE STATEMENT OF NEW BUDGET (OBLIGATIONAL) AUTHORITY FOR 1990 AND BUDGET ESTIMATES AND AMOUNTS RECOMMENDED IN THE BILL FOR 1991--Continued

Agency and item (1)	New budget (obligational) authority appropriated, 1990 (enacted to date)	Budget estimates of new (obligational) authority, 1991	New budget (obligational) authority recommended in bill	Bill compared with new budget (obligational) authority, 1990	Bill compared with budget estimates of new (obligational) authority, 1991
PROGRAM MANAGEMENT					
Research, demonstration, and evaluation:					
Regular program:					
Federal funds.....	12,857,000	13,000,000	13,000,000	+ 143,000	.....
Trust funds.....	(19,382,000)	(23,000,000)	(23,000,000)	(+ 3,618,000)	.....
Rural hospital transition demonstrations, trust funds.....	(17,761,000)	.....	(10,000,000)	(+ 5,239,000)	(+ 23,000,000)
Essential access community hospitals, trust funds.....	.....	.....	.....	(+ 10,000,000)	(+ 10,000,000)
Subtotal, research, demonstration, & evaluation.....	50,000,000	36,000,000	69,000,000	+ 19,000,000	+ 33,000,000
Medicare Contractors (Trust Funds):					
Operating funds, current.....	(1,355,342,000)	(1,410,000,000)	(1,446,500,000)	(+ 91,158,000)	(+ 36,500,000)
Contingency reserve fund.....	(98,672,000)	(173,000,000)	(136,500,000)	(+ 37,828,000)	(-36,500,000)
Subtotal, Contractors.....	(1,454,014,000)	(1,583,000,000)	(1,583,000,000)	.....	.....
State Certification:					
Medicare certification, trust funds.....	(91,214,000)	(155,100,000)	(155,100,000)	(+ 63,886,000)	.....
General program support, federal funds.....	6,469,000	8,336,000	8,336,000	+ 1,867,000	.....
Proposed legislation, user fees, trust funds.....	.....	(-155,100,000)	.....	.....	(+ 155,100,000)
Proposed legislation, user fees, federal funds.....	.....	-8,336,000	.....	.....	+ 8,336,000
Subtotal, State certification.....	(97,683,000)	.....	(163,436,000)	(+ 65,753,000)	(+ 163,436,000)
Federal Administration:					
Federal funds.....	81,509,000	83,878,000	83,878,000	+ 2,369,000	.....
Less current law user fees.....	-283,000	-248,000	-248,000	+ 35,000	.....
Trust funds.....	(262,491,000)	(232,538,000)	(232,538,000)	(-29,953,000)	.....
Proposed legislation, user fees, trust funds.....	.....	(-24,567,000)	.....	.....	(+ 24,567,000)

Proposed legislation, user fees, federal funds.....						+ 6,551,000
Subtotal, Federal Administration	(343,717,000)	(285,050,000)	(316,168,000)	(-27,549,000)	(+ 31,118,000)	
Total, Program management.....	1,945,414,000	1,904,050,000	2,131,604,000	+ 186,190,000	+ 227,554,000	
Federal funds.....	100,552,000	90,079,000	104,966,000	+ 4,414,000	+ 14,887,000	
Trust funds.....	(1,844,862,000)	(1,813,971,000)	(2,026,638,000)	(+ 181,776,000)	(+ 212,667,000)	
HMO LOAN AND LOAN GUARANTEE FUND 1/.....	4,930,000			-4,930,000		
Total, Health Care Financing Administration:						
Federal funds.....	78,073,484,000	84,047,588,000	84,175,932,000	+ 6,102,448,000	+ 128,344,000	
Current year, FY 1991	(67,673,484,000)	(71,647,588,000)	(71,775,932,000)	(+ 4,102,448,000)	(+ 128,344,000)	
New advance, 1st quarter, FY 1992.....	(10,400,000,000)	(12,400,000,000)	(12,400,000,000)	(+ 2,000,000,000)		
Trust funds.....	(1,844,862,000)	(1,813,971,000)	(2,026,638,000)	(+ 181,776,000)	(+ 212,667,000)	
SOCIAL SECURITY ADMINISTRATION						
PAYMENTS TO SOCIAL SECURITY TRUST FUNDS.....	191,968,000	46,958,000	46,958,000	-145,010,000		
SPECIAL BENEFITS FOR DISABLED COAL MINERS						
Benefit payments.....	863,422,000	834,000,000	834,000,000	-29,422,000		
Administration.....	6,831,000	7,081,000	7,081,000	+ 250,000		
Subtotal, Black Lung, FY 1991 program level.....	870,253,000	841,081,000	841,081,000	-29,172,000		
Less funds advanced in prior year	-211,000,000	-215,000,000	-215,000,000	-4,000,000		
Total, Black Lung, current request, FY 1991.....	659,253,000	626,081,000	626,081,000	-33,172,000		
New advance, 1st quarter, FY 1992.....	215,000,000	203,000,000	203,000,000	-12,000,000		
1/ Sequester amount not reflected correctly on President's budget.						

COMPARATIVE STATEMENT OF NEW BUDGET (OBLIGATIONAL) AUTHORITY FOR 1990 AND BUDGET ESTIMATES AND AMOUNTS RECOMMENDED IN THE BILL FOR 1991--Continued

Agency and item	(2) New budget (obligational) authority appropriated, 1990 (enclosed to date)	(3) Budget estimates of new (obligational) authority, 1991	(4) New budget (obligational) authority recommended in bill	(5) Bill compared with new budget (obligational) authority, 1990	(6) Bill compared with budget estimates of new (obligational) authority, 1991
SUPPLEMENTAL SECURITY INCOME 1/					
Federal benefit payments.....	11,185,613,000	13,913,000,000	13,913,000,000	+ 2,727,387,000	.....
Beneficiary services.....	13,739,000	27,717,000	27,717,000	+ 13,978,000	.....
Research demonstration.....	5,275,000	5,275,000	5,275,000	.....	+ 3,000,000
Administration.....	1,090,131,000	1,212,602,000	1,212,602,000	+ 122,471,000	.....
Subtotal, SSI FY 1991 program level.....	12,294,758,000	15,155,594,000	15,158,594,000	+ 2,863,836,000	+ 3,000,000
Less funds advanced in prior year.....	-2,936,000,000	-3,157,000,000	-3,157,000,000	-221,000,000	.....
Total, SSI, current request, FY 1991.....	9,358,758,000	11,998,594,000	12,001,594,000	+ 2,642,836,000	+ 3,000,000
New advance, 1st quarter, FY 1992.....	3,157,000,000	3,550,000,000	3,550,000,000	+ 393,000,000	.....
LIMITATION ON ADMINISTRATIVE EXPENSES (Trust Funds)	(3,837,389,000)	(4,166,974,000)	(4,166,974,000)	(+ 329,585,000)	.....
(Contingency reserve, non-add).....	(50,000,000)	(50,000,000)	(50,000,000)	.....	.....
Total, Social Security Administration:					
Federal funds.....	13,581,979,000	16,424,633,000	16,427,633,000	+ 2,845,654,000	+ 3,000,000
Current year FY 1991.....	(10,209,979,000)	(12,671,633,000)	(12,674,633,000)	(+ 2,464,654,000)	(+ 3,000,000)
New advances, 1st quarter FY 1992.....	(3,372,000,000)	(3,753,000,000)	(3,753,000,000)	(+ 381,000,000)	.....
Trust funds.....	(3,837,389,000)	(4,166,974,000)	(4,166,974,000)	(+ 329,585,000)	.....

1/ Excludes \$55,000,000 in legislative savings proposed for later transmittal.

FAMILY SUPPORT ADMINISTRATION 1/

FAMILY SUPPORT PAYMENTS TO STATES 2/

Aid to Families with Dependent Children (AFDC).....	9,261,706,000	9,999,000,000	9,999,000,000	+ 737,294,000
Payments to territories.....	16,346,000	16,346,000	16,346,000	
Emergency assistance, incl. welfare hotel demos.....	204,000,000	194,000,000	194,000,000	-10,000,000
Repatriation.....	1,000,000	1,000,000	1,000,000	
State and local welfare administration.....	1,504,500,000	1,471,900,000	1,471,900,000	-32,600,000
Work activities / child care.....	206,000,000	489,000,000	489,000,000	+ 283,000,000
Regulatory savings.....		-35,000,000	-35,000,000	-35,000,000
Subtotal, Welfare payments.....	11,193,552,000	12,136,246,000	12,136,246,000	+ 942,694,000
Child Support Enforcement:				
State and local administration.....	1,059,000,000	1,197,000,000	1,197,000,000	+ 138,000,000
Federal incentive payments.....	276,000,000	332,000,000	332,000,000	+ 56,000,000
Less federal share collections.....	-836,000,000	-1,008,000,000	-1,008,000,000	-172,000,000
Subtotal, Child support.....	499,000,000	521,000,000	521,000,000	+ 22,000,000
Total, Payments, FY 1991 program level.....	11,692,552,000	12,657,246,000	12,657,246,000	+ 964,694,000
Less funds advanced in previous years.....	-2,700,000,000	-3,000,000,000	-3,000,000,000	-300,000,000
Total, Payments, current request, FY 1991.....	8,992,552,000	9,657,246,000	9,657,246,000	+ 664,694,000
New advance, 1st quarter, FY 1992.....	3,000,000,000	3,300,000,000	3,300,000,000	+ 300,000,000

1/ Excludes Administration proposal to shift USDA Fiscal Assistance to Puerto Rico Program to FSA.

2/ Excludes legislative savings of \$32.4 million proposed for later transmittal.

COMPARATIVE STATEMENT OF NEW BUDGET (OBLIGATIONAL) AUTHORITY FOR 1990 AND BUDGET ESTIMATES AND AMOUNTS RECOMMENDED IN THE BILL FOR 1991--Continued

Agency and item (1)	New budget (obligational) authority appropriated, 1990 (enacted to date)	Budget estimates of new (obligational) authority, 1991	New budget (obligational) authority recommended in bill	Bill compared with new budget (obligational) authority, 1990	Bill compared with budget estimates of new (obliga- tional) authority, 1991
PAYMENTS TO STATES FOR AFDC WORK PROGRAMS 1/					
New Jobs Activities program.....	443,038,000	1,000,000,000	1,000,000,000	+ 556,962,000	.....
WIN Phaseout	31,200,000	.....	.....	-31,200,000	.....
Total, AFDC work programs	474,238,000	1,000,000,000	1,000,000,000	+ 525,762,000	.....
LOW INCOME HOME ENERGY ASSISTANCE					
Energy Assistance Block Grant	(1,393,000,000)	(1,050,000,000)	DEFER	DEFER	DEFER
Dire emergency supplemental.....	(50,000,000)	.....	DEFER	DEFER	DEFER
Total, Low income home energy assistance	(1,443,000,000)	(1,050,000,000)	DEFER	DEFER	DEFER
REFUGEE AND ENTRANT ASSISTANCE					
Cash and medical assistance 2/.....	(210,000,000)	(210,000,000)	DEFER	DEFER	DEFER
Social services	(75,000,000)	(75,000,000)	DEFER	DEFER	DEFER
Voluntary agency program	(40,000,000)	(40,000,000)	DEFER	DEFER	DEFER
Preventive health.....	(5,770,000)	(5,770,000)	DEFER	DEFER	DEFER
Targeted assistance	(44,052,000)	(38,052,000)	DEFER	DEFER	DEFER
Total, Refugee Resettlement.....	(374,822,000)	(368,822,000)	DEFER	DEFER	DEFER

1/ Reflects reprogramming approved 4/11/90.

2/ Includes State administrative costs.

COMPARATIVE STATEMENT OF NEW BUDGET (OBLIGATIONAL) AUTHORITY FOR 1990 AND BUDGET ESTIMATES AND AMOUNTS RECOMMENDED IN THE BILL FOR 1991--Continued

Agency and item (1)	New budget (obligational) authority appropriated, 1990 (enacted to date) (2)	Budget estimates of new (obligational) authority, 1991 (3)	New budget (obligational) authority recommended in bill (4)	Bill compared with new budget (obligational) authority, 1990 (5)	Bill compared with budget estimates of new (obligational) authority, 1991 (6)
PROGRAM ADMINISTRATION					
Federal Administration.....					
Proposed user fees.....	75,628,000	74,950,000	74,950,000	-678,000	.....
Research & evaluation.....	9,825,000	-2,000,000	-1,000,000	-1,000,000	+1,000,000
		4,250,000	6,250,000	-3,575,000	+2,000,000
Total, program administration.....	85,453,000	77,200,000	80,200,000	-5,253,000	+3,000,000
Total, Family Support Administration.....	12,540,063,000	14,034,446,000	14,037,446,000	+1,497,383,000	+3,000,000
Current year.....	(8,984,819,000)	(10,734,446,000)	(10,737,446,000)	(+1,752,627,000)	(+3,000,000)
FY 1992.....	(3,555,244,000)	(3,300,000,000)	(3,300,000,000)	(-255,244,000)	.....
Unauthorized, not considered by House.....	(2,214,643,000)	(1,452,781,000)	DEFER	DEFER	DEFER
ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES					
SOCIAL SERVICES BLOCK GRANT (TITLE XX).....	2,762,200,000	2,800,000,000	2,800,000,000	+37,800,000	.....
HUMAN DEVELOPMENT SERVICES					
Programs for Children, Youth, and Families:					
Head start.....	(1,552,000,000)	(1,886,315,000)	DEFER	DEFER	DEFER
Child development associate scholarships.....	(1,431,000)	(1,431,000)	DEFER	DEFER	DEFER
Family crisis program:					
Child abuse state grants.....	11,567,000	11,523,000	20,000,000	+8,433,000	+8,477,000
Child abuse challenge grants.....	4,934,000	4,934,000	5,000,000	+66,000	+66,000
Runaway and homeless youth.....	28,785,000	28,785,000	36,000,000	+7,215,000	+7,215,000
Family violence.....	8,273,000	8,273,000	13,273,000	+5,000,000	+5,000,000
Abandoned infants assistance.....	9,867,000	9,867,000	9,867,000	.....	.....
Emergency protection grants - substance abuse.....			20,000,000	+20,000,000	+20,000,000
Subtotal, family crisis.....	63,426,000	63,382,000	104,140,000	+40,714,000	+40,758,000

Dependent Care Planning and Development	(13,178,000)	(13,178,000)	DEFER	DEFER
Child welfare assistance	252,648,000	252,648,000	280,000,000	+ 27,352,000
Proposed legislation .....	.....	47,352,000	.....	-47,352,000
Subtotal	316,074,000	363,382,000	384,140,000	+ 20,758,000
Programs for the Aging:				
Grants to States:				
Supportive Services and Centers	271,987,000	272,961,000	298,000,000	+ 25,039,000
Ombudsman activities	973,000	.....	3,000,000	+ 3,000,000
Nutrition:				
Congregate meals	351,925,000	351,925,000	370,000,000	+ 18,075,000
Home-delivered meals	78,981,000	78,981,000	90,000,000	+ 11,019,000
Federal Council on Aging 1/ .....	.....	.....	185,000	+ 185,000
Grants to Indians	12,541,000	12,541,000	14,000,000	+ 1,459,000
Frail elderly in-home services	5,756,000	5,756,000	5,756,000	.....
Subtotal, Aging programs	722,163,000	722,164,000	780,941,000	+ 58,778,000
Developmental disabilities program:				
State grants	(61,939,000)	(61,939,000)	DEFER	DEFER
Protection and advocacy	(20,484,000)	(20,484,000)	DEFER	DEFER
Subtotal, Developmental disabilities	(82,423,000)	(82,423,000)	DEFER	DEFER
Native American Programs	31,711,000	31,711,000	34,200,000	+ 2,489,000
Human services research, training & demonstration:				
Comprehensive child development centers	24,668,000	24,668,000	24,668,000	.....
Child abuse discretionary activities	13,478,000	13,523,000	15,000,000	+ 1,477,000
Runaway youth - transitional living	9,867,000	9,867,000	9,867,000	.....
Runaway youth activities - drugs	14,801,000	14,801,000	14,801,000	.....

1/ President's budget proposes to fund under Program Direction.

COMPARATIVE STATEMENT OF NEW BUDGET (OBLIGATIONAL) AUTHORITY FOR 1990 AND BUDGET ESTIMATES AND AMOUNTS RECOMMENDED IN THE BILL FOR 1991--Continued

Agency and item (1)	New budget (obligational) authority appropriated, 1990 (enacted to date) (2)	Budget estimates of new (obligational) authority, 1991 (3)	New budget (obligational) authority recommended in bill (4)	Bill compared with new budget (obligational) authority, 1990 (5)	Bill compared with budget estimates of new (obligational) authority, 1991 (6)
Youth gang substance abuse.....	14,801,000	14,801,000	14,801,000	.....	.....
Temporary childcare/crisis nurseries.....	8,328,000	8,328,000	8,328,000	.....	.....
Child welfare training.....	3,647,000	3,647,000	3,647,000	.....	.....
Child welfare research.....	7,517,000	13,517,000	13,517,000	+6,000,000	.....
Adoption opportunities.....	6,736,000	6,736,000	13,000,000	+6,264,000	+6,264,000
Aging research, training and special projects.....	25,332,000	26,332,000	27,332,000	+2,000,000	+1,000,000
Social services research.....	3,475,000	3,475,000	3,975,000	+500,000	+500,000
Developmental disabilities special projects.....	(2,862,000)	(2,862,000)	DEFER	DEFER	DEFER
Developmental disabilities university affiliated programs.....	(13,192,000)	(13,192,000)	DEFER	DEFER	DEFER
Total, Human Services Res, Trng & demonstration	132,650,000	139,695,000	148,936,000	+16,286,000	+9,241,000
Program direction	68,313,000	71,149,000	75,000,000	+6,687,000	+3,851,000
Total, Human Development Services	1,270,911,000	1,328,101,000	1,423,217,000	+152,306,000	+95,116,000
Unauthorized, not considered by House.....	(1,665,086,000)	(1,999,401,000)	DEFER	DEFER	DEFER
PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE					
Foster care.....	1,200,061,000	1,877,712,000	1,877,712,000	+677,651,000	.....
Proposed legislation.....	.....	-160,909,000	.....	.....	+160,909,000
Adoption assistance.....	124,855,000	150,480,000	150,480,000	+25,625,000	.....
Independent living.....	50,000,000	60,000,000	60,000,000	+10,000,000	.....
Prior year claims.....	.....	544,000,000	544,000,000	+544,000,000	.....
Total, Payments to States.....	1,374,916,000	2,471,283,000	2,632,192,000	+1,257,276,000	+160,909,000
Total, Asst. Sec. for Human Development	5,408,027,000	6,599,384,000	6,855,409,000	+1,447,382,000	+256,025,000
Unauthorized, not considered by House.....	(1,665,086,000)	(1,999,401,000)	DEFER	DEFER	DEFER

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATION BILL, 1991

OCTOBER 10 (legislative day, OCTOBER 2), 1990.—Ordered to be printed

Mr. HARKIN, from the Committee on Appropriations,
submitted the following

REPORT

[To accompany H.R. 5257]

The Committee on Appropriations, to which was referred the bill (H.R. 5257) making appropriations for the Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 1991, and for other purposes, reports the same to the Senate with various amendments and presents herewith information relative to the changes recommended.

Amount of budget authority

Amount of House bill	\$170,674,442,000
Amount of Senate bill over House bill	¹ +12,659,668,000
Total bill as reported to Senate.....	¹ 183,334,110,000
Amount of adjusted appropriations, 1990	159,022,100,000
Budget estimates, 1991	171,736,511,000
The bill as reported to the Senate:	
Over the adjusted appropriations for 1990	+24,312,010,000
Over the budget estimates for 1991.....	+11,597,599,000

¹ Includes \$6,666,646,000 for budget requests and new programs not considered by the House, but addressed by the Senate Appropriations Committee. Amounts include subsequent year advances, but exclude prior year advances.

CONTENTS

Budget estimates.....	Page 4
Title I—Department of Labor:	
Employment and Training Administration	7
Labor-Management Services	18
Pension Benefit Guaranty Corporation	19
Employment Standards Administration	20
Occupational Safety and Health Administration.....	23
Mine Safety and Health Administration.....	25
Bureau of Labor Statistics.....	26
Departmental management.....	27
Office of the Inspector General	31
Title II—Department of Health and Human Services:	
Acquired immune deficiency syndrome.....	37
Health Resources and Services Administration	40
Centers for Disease Control.....	64
National Institutes of Health.....	80
Alcohol, Drug Abuse, and Mental Health Administration	155
Office of the Assistant Secretary for Health	172
Health Care Financing Administration	179
Social Security Administration	187
Family Support Administration	193
Assistant Secretary for Human Development Services	201
Departmental management.....	213
Title III—Department of Education:	
Compensatory education for the disadvantaged.....	218
Impact aid.....	223
School improvement programs	227
Bilingual, immigrant and refugee education	243
Education for the handicapped.....	245
Rehabilitation services and handicapped research.....	252
Special institutions for persons with disabilities	259
National Technical Institute for the Deaf.....	259
Gallaudet University.....	260
Vocational and adult education.....	261
Student financial assistance.....	268
Guaranteed student loans.....	272
Higher education	273
Howard University.....	282
College housing and academic facilities loans.....	283
Office of Educational Research and Improvement	283
Libraries.....	289
Departmental management.....	291
Office for Civil Rights.....	292
Office of the Inspector General	293
Title IV—Related agencies:	
ACTION	294
Corporation for Public Broadcasting	297
Federal Mediation and Conciliation Service.....	298
Federal Mine Safety and Health Review Commission.....	299
Joint Study Commission on Postsecondary Institutional Recognition.....	299
National Commission on Acquired Immune Deficiency Syndrome.....	300
National Commission on Children	300
National Commission on Libraries and Information Science.....	300

	Page
Title IV—Related agencies—Continued	
National Commission to Prevent Infant Mortality	301
National Commission on the Responsibilities for Financing Postsecondary Education	301
National Council on Disability	301
National Labor Relations Board.....	302
National Mediation Board.....	302
Occupational Safety and Health Review Commission	302
Physician Payment Review Commission	303
Prospective Payment Assessment Commission	303
Railroad Retirement Board	305
Soldiers' and Airmen's Home	308
U.S. Institute of Peace.....	309
White House Conference on Library and Information Services	309
Title V—General provisions	310
Budgetary impact of bill.....	310
Compliance with standing rules of the Senate.....	310
Comparative statement of new budget authority.....	312

SUMMARY OF BUDGET ESTIMATES AND COMMITTEE RECOMMENDATIONS

For fiscal year 1991, the Committee recommends total budget authority of \$183,334,110,000 for the Departments of Labor, Health and Human Services, Education, and Related Agencies. Of this amount \$20,553,000,000 is for subsequent year advances. Mandatory programs amount to \$131,560,511,000, or 72 percent of the total. The remaining \$51,773,599,000, or 28 percent is for discretionary appropriations, which is an increase of \$5,622,915,000 over the President's budget request and \$6,947,890,000 more than the enacted fiscal year 1990 level.

The Committee recommendation includes \$6,666,646,000 for unauthorized programs not considered by the House, including both new programs and expiring authorizations in the process of being renewed.

ALLOCATION CEILING

Allocation ceilings, which are based on current year budget authority and outlays, do not match the preceding bill total amounts which reflect subsequent year advances.

Consistent with Budget Committee scorekeeping, the recommendations result in discretionary outlays of \$53,534,000,000, the full amount of the subcommittee's discretionary allocation pursuant to section 302(b) of the Congressional Budget Act of 1974. Total discretionary budget authority is \$50,709,000,000, which is also the full amount of the allocation ceiling.

HIGHLIGHTS OF THE BILL

Job training programs.—\$4,120,788,000 is included for Labor Department training and employment services. This includes \$550,000,000 for dislocated worker assistance. This level is \$150,000,000 over the administration's request. The \$881,600,000 recommended for the Job Corps represents nearly a 10-percent increase over current funding.

Employment of older Americans.—\$400,000,000 is included for the employment of older Americans. This represents an increase of \$32,987,000 over 1990 to help offset the impact of higher minimum wages. This program provides jobs for low-income persons aged 55 and over in a variety of community service activities.

State employment security agencies.—\$2,836,040,000 maintains current services for job service offices and unemployment insurance service operations; \$20,000,000 is included to continue the Targeted Jobs Tax Credit Program, and \$25,000,000 for automation of employment offices, for which no funds were requested by the administration.

Black lung.—\$919,552,000 is included for Labor Department black lung benefit payments and administrative costs; this includes funds to restore 16 Benefits Review Board staff and 10 Office of Administrative Law Judges staff to eliminate the black lung claims backlog.

AIDS.—\$2,184,955,000 is provided for AIDS research and treatment activities. This is \$518,234,000 over the House and \$561,607,000 over the administration's 1991 request. We have funded the AIDS care bill at a level of \$600,000,000, although \$441,000,000 of the total, because of budget constraints, is available on a delayed basis. We have provided a \$10,000,000 increase for pediatric AIDS basic research.

National Health Service Corps.—\$107,882,000 is provided for this program, an increase of \$57,163,000 over last year's amount, to increase the numbers of health professionals in underserved communities.

Maternal and child health block grant.—\$605,000,000 is provided for the MCH block grant, an increase of \$51,373,000 over last year's funding.

Immunization.—\$203,122,000 for childhood immunization programs. This is an increase of \$50,400,000 over the administration's request.

Alzheimer's research.—\$305,000,000 is provided for Alzheimer's disease research. This doubles all the funding in the bill provided for Alzheimer's research.

Mental health research.—\$491,143,000 is provided for mental health research. This represents an increase of \$77,652,000 over the administration request and \$101,604,000 over the fiscal year 1990 amount.

Substance abuse.—\$2,984,142,000 is provided for substance abuse treatment, prevention, and research. This is over \$345,000,000 or 13 percent above 1990 levels.

Head Start.—\$2,000,000,000 is provided for the Head Start Program. This is \$448,000,000 over the 1990 level and \$114,000,000 over the 1991 request.

Programs for the aging.—\$787,000,000 is provided for programs for the aging. This is almost \$65,000,000 more than the 1991 request and \$6,000,000 more than the level recommended by the House.

Low-Income Home Energy Assistance Program.—\$1,450,000,000 is provided for the Low Income Home Energy Assistance program, \$400,000,000 over the administration request.

Chapter 1.—\$6,380,000,000 is provided for chapter 1 education programs. This is \$1,000,000,000 over last year, \$540,000,000 over the request for 1991, and \$154,000,000 over the House bill.

Pell Grant Program.—\$5,336,000,000 is provided for the Pell Grant Program. This is \$430,000,000 over the 1991 request and \$293,000,000 over the House bill. The Committee has increased the maximum grant to \$2,400.

TRIO.—\$342,000,000 is provided for TRIO, the special programs for disadvantaged students. This is an increase of \$100,178,000 over last year and the same as the House allowance.

Vocational and adult education.—\$1,200,000,000 is provided for vocational and adult education. This is an increase of \$111,400,000 over last year.

REPROGRAMMING AND INITIATION OF NEW PROGRAMS

The Committee has a particular interest in being informed of reprogrammings which, although they may not change either the total amount available in an account or any of the purposes for which the appropriation is legally available, represent a significant departure from budget plans presented to the Committee in an agency's budget justifications.

Consequently, the Committee directs that the departments and agencies funded through this bill notify the chairman of the Committee prior to reprogramming of funds in excess of 10 percent or \$250,000, whichever is less, between programs, activities, or elements. The Committee desires to be notified of reprogramming actions which involve less than the above-mentioned amounts if such actions would have the effect of changing an agency's funding requirements in future years or if programs or projects specifically cited in the Committee's reports are affected.

PAY

The Committee has included a general provision (sec. 514) to reduce salaries and expenses amounts for the Departments of Labor, HHS, and Education, to reflect absorption of 1991 Federal pay raise costs. This requirement results in a total savings of \$121,000,000 below the President's budget and House allowance.

The Committee has retained the existing bill language percentage distribution of resources between States and national contractors of 22 percent and 78 percent respectively.

The Committee recommends that the Secretary increase the level of funding in the national contracts to serve older American Indians and Pacific Island and Asian Americans by \$2,500,000 for each contract. This level of funding will help to ensure that these populations can be served adequately on a national basis.

FEDERAL UNEMPLOYMENT BENEFITS AND ALLOWANCES

Appropriations, 1990	\$280,024,000
Budget estimate, 1991	230,500,000
House allowance	230,500,000
Committee recommendation	269,500,000

The Committee recommends an appropriation of \$269,500,000 for this account, \$39,000,000 more than the administration request and the House allowance and \$10,524,000 less than the 1990 comparable amount, \$280,024,000.

These funds provide for the payment of trade adjustment assistance benefits training and allowances to workers adversely affected by increased imports and certain benefits and allowances under the Redwood National Park Amendments of 1978.

The amount requested in the budget does not reflect the change due to the latest economic assumptions, those used for the 1990 midsession review. The Committee recommends that this change be included in the bill, specifically, that the amount for Trade Act unemployment benefits be increased by \$39,000,000, over the request and the House allowance, to \$198,000,000, which is \$2,644,000 over the comparable amount provided for benefits in 1990. The Committee also recommends \$71,000,000 for trade adjustment assistance training and allowances, the amount of the request and the House allowance and \$7,880,000 less than for 1990. For unemployment assistance and payments under other Federal unemployment programs, the Committee recommends \$500,000, the amount of the request and the House allowance. This \$500,000 is authorized under the Redwood National Park Amendments of 1978, for which no specific amount of funds was provided in 1990. The changes from the comparable 1990 fiscal year level reflect anticipated economic and workload conditions and are considered built-in for budgetary purposes.

Funds for trade training, included in this account, were formerly included in the "Training and employment services" account, but were consolidated into this account in 1990 for budgetary purposes.

STATE UNEMPLOYMENT INSURANCE AND EMPLOYMENT SERVICE OPERATIONS

Appropriations, 1990	\$22,000,000
Budget estimate, 1991	23,100,000
House allowance	25,600,000
Committee recommendation	23,100,000

The Committee recommends a Federal fund appropriation of \$23,100,000 for State unemployment insurance and employment

service operations, the amount of the budget request and \$2,500,000 below the House allowance. The balance of the funding for this account is derived from the "Employment Security Administration" account of the unemployment trust fund. The Committee recommends that a trust fund limitation of \$2,848,546,000, which includes sums previously appropriated, be provided. This amount is \$159,746,000 more than the administration request, \$35,646,000 more than the House allowance, and \$221,780,000 more than the comparable amount provided for 1990.

This appropriation recommendation provides funding to State employment security agencies for the administration of Federal and State compensation laws and local public employment offices. In addition, the recommendation includes a contingency fund to meet increases in the costs of administering the unemployment insurance portion of these employment security operations.

The Committee recommendation for the employment service totals \$928,900,000, including sums previously appropriated, and consists of \$23,100,000 in Federal funds and \$905,800,000 in trust funds. This is \$147,400,000 more than the amount of the administration request and is \$81,209,000 more than the comparable amount provided for 1990. The recommendation is \$55,000,000 above the House allowance.

Of the total amount provided for the employment service, \$825,000,000, \$21,700,000 in Federal funds and \$803,300,000 in trust funds, is for State grants. These grants are distributed to the States by a demographically based formula enacted as part of the 1982 amendments to the Wagner-Peyser Act. They provide funding for State public employment services such as job counseling, testing, and referral to employers. This level, provided by the Committee, is \$102,400,000 more than the budget request in order to provide for continuation of the program at approximately the 1990 workload level plus inflation.

The balance of the funds provided for the employment service is \$91,400,000, plus \$12,500,000 appropriated in 1990 for obligation in 1991, for a total of \$103,900,000. This consists of \$1,400,000 in Federal funds and \$102,500,000 in trust funds for national activities. This is \$45,000,000 more than the agency request and \$35,048,000 more than the comparable 1990 amount.

The recommendation reflects a built-in increase of \$1,724,000 for inflation, and program increases of \$635,000 for alien certification, test development, automation, occupational analysis field centers, and \$1,000,000 for improvement of the general aptitude test battery [GATB]. The Committee also has provided for the continuation of funding of the Targeted Jobs Tax Credit [TJTC] Program at a 1991 level of \$20,000,000. The budget request proposed elimination of the TJTC, however, the Committee has provided funding in anticipation of extension of the program for at least one more year. In addition the Committee has provided \$25,000,000 to continue funding toward full automation of the public employment service.

The Committee has provided these funds to build upon the investment begun in fiscal year 1990 toward full automation of the public employment service. The Committee expects that grants will be awarded to State employment security agencies to expand and

improve system automation in order to facilitate faster, more efficient, and better quality service to job seekers and employers.

The Committee concurs with the budget request for a program decrease of \$958,000 to reduce funding for the amortization of retirement plans for States which had independent retirement plans in their State employment service agencies prior to 1980.

The Committee also recommends the financing change, requested in the budget submission, to shift \$1,000,000 in the base financing of the employment service from trust to general funding to maintain consistency with section 901 of the Social Security Act.

For the unemployment insurance service, the Committee recommends a total of \$1,942,746,000 in trust funds for the unemployment insurance service, \$12,346,000 over the request, \$9,354,000 under the House allowance, and \$141,671,000 more than the comparable 1990 level.

Of the amounts provided for the unemployment insurance service, \$1,403,751,000 is recommended for State operations, \$146,078,000 more than the 1990 comparable amount. These funds are given as administrative grants to the States to pay for the administration of unemployment compensation to workers, and to collect State unemployment taxes from employers. The recommendation includes \$18,882,000 for State unemployment insurance automation activities. In addition, \$285,120,000 is provided for State integrity activities, the amount of the request and \$37,603,000 more than the comparable 1990 amount. These funds are to be used for quality control, to assess and reduce errors in the collection of State taxes and payment of benefits. The Committee has, further, provided \$6,366,000 for national activities, which cover interstate or multistate operations. This amount is also the amount requested and is \$866,000 more than the comparable 1990 amount.

The Committee concurs with the House allowance of \$247,509,000 for the unemployment insurance service contingency fund which covers the cost of changes which may occur in State unemployment law, in unemployment claims, and in State salary rates.

The Committee recommendation for the unemployment insurance service provides for built-in increases of \$100,421,000 for State salary and benefit increases, \$10,602,000 for State nonpersonnel costs, \$15,475,000 for the normal growth of the covered work force and subject employers, and an increase of \$78,671,000, to reflect economic changes. One built-in decrease of \$4,037,000 is recommended, for savings resulting from automation grants provided over the last few years.

Program changes consist of increases of \$200,000 for interstate satellite communications, \$24,593,000 for integrity operations, and \$3,000,000 for the Systematic Alien Verification Eligibility Program.

The Committee supported the demonstration of alternative service delivery activities by State employment services, and believes that an objective evaluation of such demonstration alternatives is the best means to accomplish this objective. The Committee recommends that the Secretary of Labor consider providing administrative flexibility to States in areas where current administrative provisions and practices would, in the judgment of the Secretary, un-

necessarily impede implementation of the demonstration for a period not to exceed 3 years.

ADVANCES TO THE UNEMPLOYMENT TRUST FUND AND OTHER FUNDS

Appropriations, 1990	\$33,000,000
Budget estimate, 1991	328,000,000
House allowance	328,000,000
Committee recommendation	328,000,000

The Committee recommends an appropriation of \$328,000,000 for advances to the unemployment trust fund and other funds. This is the amount of the administration request and the House allowance. The recommendation is \$295,000,000 more than the comparable amount for 1990.

This appropriation provides Federal funds necessary to make required payments for unemployment compensation, black lung, and other benefits, whenever the fund balances in those accounts prove insufficient to make payments which are mandatory under the law.

The entire request of the \$328,000,000, together with \$33,000,000 available in funds unused in, and carried over from, 1990, will be available for advances to the black lung disability trust fund, so that mandatory black lung disability payments and loan interest payments can be made. The requested amount is required to ensure an adequate cash flow for the black lung disability trust fund, pay mandatory loan interest to the U.S. Treasury, and to cover any shortfall in coal taxes. Of the total \$361,000,000 available for 1991, \$328,000,000 is to make interest payments to the U.S. Treasury and \$33,000,000 is for cash flow and benefit payments.

In fiscal year 1991, should the need for advances arise in any of the other accounts eligible to receive them, due to unanticipated changes in the economic situation, advances will be made to the extent funds are available.

LABOR-MANAGEMENT SERVICES

Appropriations, 1990	\$73,949,000
Budget estimate, 1991	90,051,000
House allowance	90,051,000
Committee recommendation	90,051,000

The Committee recommends an appropriation of \$90,051,000 for 1,106 full-time equivalent positions for labor-management services. The recommended appropriation is the same as the House allowance and the budget estimate. It is \$16,102,000 and 110 full-time equivalent positions more than fiscal 1990 comparable amounts.

The labor-management services appropriation incorporates the Bureau of Labor-Management Relations and Cooperative Programs, the Office of Labor-Management Standards, and the Pension and Welfare Benefits Administration. The Bureau of Labor-Management Relations and Cooperative Programs supports high-priority labor relations functions designed to encourage labor-management cooperation for continued enhancement of productivity and improved competitive posture of the United States. The Office of Labor-Management Standards combats serious violations of the Labor-Management Reporting and Disclosure Act and related acts covering public employee unions which interfere with democratic

enormous hardship for families, wastes precious human resources, and creates a tremendous drain upon both the public Treasury and the personal savings of families. Unfortunately, recent studies have determined that more than 4 million Americans are suffering from Alzheimer's disease or nearly twice as many as were previously thought at an estimated cost to society of \$90,000,000,000 per year. The same studies project that with the rapid growth of the elderly population, an alarming 14 million persons could be afflicted by the middle of the next century.

Alzheimer's disease is already costing society over \$90,000,000,000 annually, taking into account nursing home care, the cost of informal care at home, and lost wages. If this Nation does not take steps to head off this problem, it will cost far more to come to terms with the ravages of Alzheimer's disease in the future, both in terms of family resources and public expenditures. The projected increase in the number of Alzheimer victims also will have a profound effect on a health care system that is already strained to the limit. Health and nursing care facilities will rapidly become understaffed and overcrowded institutions from which death will provide the only certain hope of release.

For all of these reasons, the Committee believes Alzheimer's research should be increased to a level commensurate with the public health impact of this disorder. Now is the time to embark on a national program to cure, treat, and ultimately prevent this insidious disease from destroying future generations. To that end, the Committee bill contains the following amounts to carry out biomedical and services research on Alzheimer's disease.

	1989	1990 estimate	Estimate	Committee recommendation
National Institutes of Health.....	\$104,982,000	\$119,725,000	\$124,487,000	¹ \$265,160,000
Centers for Disease Control.....	154,500	155,500	171,000	800,000
Alcohol, Drug Abuse, and Mental Health Administration.....	23,632,000	26,210,000	26,644,000	36,644,000
Health Care and Financing Administration.....	1,100,000	1,000,000	1,000,000	2,000,000
Office of Human Development Services, Administration on Aging.....	470,000	900,000	500,000	1,000,000
Total.....	130,338,500	147,990,500	152,802,000	305,604,000

¹ Funding for the National Institute on Aging increases by \$117,229,000; funding for the National Institute on Neurological Disorders and Stroke increases by \$23,444,000.

ACQUIRED IMMUNE DEFICIENCY SYNDROME [AIDS]

Appropriations, 1990.....	\$1,529,658,000
Budget estimate, 1991.....	1,630,643,000
House allowance.....	1,147,113,000
Committee recommendation.....	2,184,955,000

The bill includes a total of \$2,184,955,000 for Public Health Service [PHS] program activities associated with AIDS. This is \$561,607,000 more than requested by the administration, and \$518,234,000 more than provided by the House. Not included in this bill, but also within the PHS, is \$63,236,000 for the AIDS activities of the Food and Drug Administration [FDA], and \$1,013,000 for the AIDS activities of the Indian Health Service [IHS]. The appropriations for AIDS continue to significantly increase, as shown below:

Fiscal year:

1982.....	\$5,555,000
1983.....	28,736,000
1984.....	61,460,000
1985.....	108,618,000
1986.....	233,793,000
1987.....	502,455,000
1988.....	962,018,000
1989.....	1,301,012,000
1990.....	1,585,878,000
1991 estimate	2,184,955,000

In addition to the amount the Committee expects to be spent by the PHS agencies in fiscal year 1991 on AIDS, the Federal Government will spend another \$1,728,000,000 on AIDS treatment, testing, and research through Medicaid, Medicare, Social Security, and the Departments of Labor, Defense, Veteran Affairs, State, and Justice. In summary, the Federal Government will spend over \$3,900,000,000 on AIDS in fiscal year 1991 as shown in the following table:

Public Health Service	\$2,184,955,000
Medicaid (Federal share).....	870,000,000
Medicare	140,000,000
Social Security Administration.....	305,000,000
HHS Human Development/Civil Rights.....	22,000,000
Department of Veterans Affairs.....	229,000,000
Department of Defense.....	109,000,000
Agency for International Development.....	41,000,000
Department of Justice/Bureau of Prisons	9,000,000
Department of State.....	2,000,000
Department of Labor.....	1,000,000
Total.....	3,912,955,000

The table at the end of the report shows the amount included in the bill for each PHS agency and institute along with the 1990 amounts, the President's budget request, and the amount provided by the House.

Magnitude of the problem and response to date

In calendar year 1989, over 35,000 new cases of AIDS were reported, a 9-percent increase over 1988. In total, as of May 31, 1990, 136,204 AIDS cases and 83,245 AIDS-related deaths in the United States have been reported to the Centers for Disease Control [CDC] since June 1981. Of the number of reported cases, over 83,000 or 61 percent have died. In addition, of the 136,204 reported AIDS cases, 2,315 are pediatric AIDS cases (children under age 13) and 1,238 or 54 percent have died. Each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and the trust territories have reported cases of AIDS. HIV infection has become an epidemic of major proportions. Revised projections estimate that by 1993 the cumulative number of reported AIDS cases in the United States will range between 390,000 and 480,000, with cumulative deaths between 285,000 and 340,000. In 1993 alone, approximately 61,000 to 98,000 new cases are expected to be reported and between 53,000 and 76,000 persons are expected to die from complications associated with AIDS. Of critical importance is that estimates show that there are now between 580,000 and 640,000 persons alive and in-

infected with HIV and at some stage of the disease process, who could benefit from care or treatment.

The Committee continues to be impressed with the progress made against AIDS. The number of clinical trial groups has grown from 15 in 1986 to 47 and includes 15 pediatric units. The community programs for clinical research on AIDS has enabled more HIV infected minorities to gain access to clinical trials. PHS researchers are evaluating the use of early intervention strategies in delaying the onset of HIV-related disease and prolonging the quality of life of infected individuals. A number of experimental drugs are being tested against both the human virus and the opportunistic infections that most commonly affect persons with AIDS. New information and education programs, as well as expansion of existing risk assessment and prevention efforts will help reduce the chances of more people becoming infected. Approximately 633 community-based organizations receive support to implement activities aimed at preventing HIV/AIDS infection in racial and ethnic minorities.

Last year the Committee expressed concern about the difficulty that each PHS agency encountered when trying to acquire sufficient FTE's to address activities, such as AIDS, that were funded by the Congress. During the past year, the Committee has not heard concerns about problems in acquiring FTE's. The Committee is very pleased with the administration's response to this problem. Because of the importance of the issue, the Committee will continue to review this issue to assure that FTE's do not again become an obstacle in the PHS battle against AIDS and other illnesses.

The PHS should continue to expand research and prevention efforts to gain knowledge and understanding about the disease process. The PHS should give priority to education and prevention, testing of new drugs which treat opportunistic infections as well as the virus itself, vaccine development, and surveillance and epidemiologic efforts. Efforts should focus on the development, testing, and evaluation of vaccines and new therapeutic drugs, with increased access of minority populations to clinical trials, and increased involvement of community providers in clinical trials. Prevention activities should include programs that focus on expanded counseling, testing, and partner notification programs and their evaluation; programs targeting high-risk, out-of-school youth (homeless, runaways, et cetera), and IV drug abusers and their partners; increased education and training center initiatives to further train health professionals; and preventing perinatal infection. Special emphasis should also be placed on programs providing services to persons with AIDS. PHS should further develop and utilize electronic technologies to make available and disseminate HIV/AIDS-related information to scientists and the public.

Pediatric AIDS initiatives

The Committee remains greatly concerned about the escalating pediatric AIDS problem in the United States. As of May 1990, over 2,315 cases of pediatric AIDS were reported to CDC. Of these cases, 1,239 or 54 percent have died. AIDS is now the ninth leading cause of death among children 1 to 4 years old, and the seventh in young people between ages 15 and 24. Pediatric HIV infection is a complex entity with a disease process which differs from HIV infection

in adults, and as such requires specially tailored approaches to research, care, financing, and prevention. Seroprevalence studies designed to monitor the problem should be continued and perinatal prevention projects and clinical trials should be expanded. The Committee has provided \$10,000,000 for an increase of basic research in pediatric AIDS. The following table depicts funding for the last 2 years, and the fiscal year 1991 Committee recommendations:

HEALTH AND HUMAN SERVICE PEDIATRIC AIDS

(In millions of dollars)

	Fiscal year 1989	Fiscal year 1990	Fiscal year 1991—		Change
			President's budget	Senate recommendation	
Health Resources and Services Administration.....	8	15	15	15	
Centers for Disease Control.....	25	28	45	45	
National Institutes of Health.....	55	74	82	92	+10
Alcohol, Drug Abuse, and Mental Health Administration.....	8	9	14	14	
Office of Human Development Services.....	2.2	11.4	17.4	17.4	
Total.....	98.2	137.4	173.4	183.4	+10

Quality assurance

Quality diagnosis and treatment are the most important aspects of medical care. Because of mounting concern about decreasing quality of medical care (including testing, research, and treatment), decreasing access to quality care, and dramatically increasing costs of care throughout the country, the Committee directs the Department of Health and Human Services to determine what mechanisms the Department can put in place to assure and promote quality of care in this country. The Department not only pays for a significant amount of care, but also provides care directly, funds research to promote advances in quality care, and supports education and training of providers. Because of this, the Department can greatly influence the quality of medical diagnosis and treatment in this country. The Committee directs the Department to report back to the Committee by July 1, 1991, on ways of addressing quality of care throughout the Department, as well as the feasibility of establishing an office within the Office of the Secretary to direct and coordinate activities within the Department related to quality of care and quality assurance within the field of health care.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

HEALTH RESOURCES AND SERVICES

Appropriations, 1990.....	\$1,760,808,000
Budget estimate, 1991.....	1,695,957,000
House allowance.....	1,627,375,000
Committee recommendation.....	2,474,940,000

The Committee recommends an appropriation of \$2,474,940,000 for health resources and services. This is \$778,983,000 more than

the administration request, \$847,565,000 above the House allowance, and \$714,132,000 more than the fiscal year 1990 appropriation.

The HRSA appropriation supports programs that provide health care services to mothers and infants, the underserved, the elderly, the homeless, migrant farmworkers, and others. This appropriation provides Federal support for cooperative programs in community health, AIDS care, health care provider training, and health care delivery systems and facilities.

HEALTH CARE DELIVERY AND ASSISTANCE

Community health centers

The Committee has included \$477,000,000 for the Community Health Centers [CHC] Program, including \$33,476,000 requested for the infant mortality initiative. This total is \$5,215,000 more than the administration's request, \$20,086,000 over the fiscal year 1990 appropriation, and \$13,000,000 below the House allowance.

The Community Health Center Program is fundamental to Federal efforts to provide primary health care services to the Nation's growing medically indigent population. During fiscal year 1990, some 550 community health centers will serve about 5,350,000 medically underserved persons.

The Committee is deeply concerned that increased appropriations to the Community Health Center Program have not resulted in significant increases in the number of medically indigent served, nor the scope of health care services provided to this population. Rural and frontier areas of the Nation are disproportionately represented among those areas that are not served by this program.

The Committee is puzzled by the enormous disparity in annual Federal grants to health centers, which range from a low of \$55,000 to a high of over \$7,000,000 to a single grantee in 1 year. The Committee is deeply concerned that such a disparity in Federal grants is not justified either by legislative mandate or departmental policy. The Committee requests that the Department prepare a report detailing the history leading up to these extremely disparate awards, and steps that will be taken to assure a more equitable distribution of funds.

The Committee raised the concern in its fiscal year 1990 report that rural community health center grantees account for 61 percent of all grantees and serve 50 percent of all patients receiving care at community health centers, yet receive only 40 percent of grant funds. The Committee is encouraged that the gap between urban and rural grantees' funds is lessening, and anticipates that fiscal year 1991 awards will demonstrate parity between urban grantees and rural grantees.

The Committee is aware that the community health center in Davenport, IA, has expanded its service area to include residents of Lowden Lost Nation. The Committee encourages HRSA to provide funding to continue this initiative in fiscal year 1991.

The Committee is sympathetic to the concerns raised by providers of primary health care, including community and migrant health centers, regarding the availability and cost of medical malpractice insurance. The Committee requests that the General Ac-

counting Office examine the costs of such insurance to health centers and to the Federal Government, and report back to the Committee. The report should address alternatives that might reduce the cost of insurance, such as group arrangements with private insurance, mechanisms for self-insurance, such as adopted by nurse-midwives, coverage under the Federal Tort Claims Act, and other alternatives. The Committee encourages the GAO to consult health centers and other health providers, insurers, and concerned health care organizations in its examination.

The Committee continues to be concerned that HRSA has not given sufficient priority to the health care needs of Asian Americans, especially those residing on the west coast. Many of these individuals are recent arrivals to the United States who lack access to health care due to cultural and language difference. Accordingly, the Department is strongly urged to make this population a priority and further, to work closely with recognized Asian American health care organizations and provider groups to ensure that their concerns are appropriately taken into account this year. The Committee finds that the Department has the authority to target particular ethnic and/or racial groups for services to meet such special and pressing needs as these.

The Committee notes that Hurricane Hugo caused severe service disruptions in provision of primary health care services in some rural poverty areas. The Committee recommends that the Department use up to \$500,000 of the funds provided for grants to assist communities in rural poverty areas that are experiencing serious problems delivering primary health care services due to damage caused by Hurricane Hugo.

Migrant health

The Committee has included \$54,000,000 for migrant health centers, including \$2,232,000 requested for the infant mortality initiative. This amount is \$3,399,000 above the administration request, \$2,000,000 over the House amount, and \$4,657,000 more than the fiscal year 1990 appropriation.

Migrant health center grants fund primary health care services to migrants and seasonal farmworkers and their families. In fiscal year 1990, an estimated 500,000 migrants and seasonal farmworkers will be served at about 400 clinics operated by 105 grantees in 40 States and Puerto Rico.

While expanded Medicaid coverage for infant mortality prevention and maternal and child health services may benefit many Americans, Medicaid eligibility for migrants who lack a continuous place of residence remains extremely limited. The Committee has increased funding in order to reach a greater proportion of this needy population.

The Committee allocated \$500,000 in fiscal year 1990 for development of State environmental plans addressing migrant worker housing, pesticide exposure, water and sanitation, and health and social services. The Committee has provided an additional \$500,000 in fiscal year 1991 to be set aside to develop additional State environmental plans.

The Committee is concerned about the possible loss of services to migrant agricultural workers and their families and the difficulty

MATERNAL AND CHILD HEALTH AND RESOURCES DEVELOPMENT

Maternal and child health block grant

The Committee recommends \$605,000,000 for the Maternal and Child Health [MCH] Block Grant Program. This is \$51,373,000 over the fiscal year 1990 appropriation, \$6,373,000 over the House amount, and \$26,373 above the administration request for fiscal year 1991.

The MCH block grant assists States to provide adequate health care for mothers and children who otherwise do not have access to such care. According to statute, 15 percent of the funds are to be used for special projects of regional or national significance [SPRANS].

Within the SPRANS set-aside, the Committee has provided \$1,400,000 for University Affiliated Programs [UAP's] with core awards of \$527,000 or less to be distributed equally. An additional \$1,000,000 shall be obligated for the creation of two new UAP's. At least one of these programs shall address the pressing maternal and child health needs of the rural Appalachian region. For example, West Virginia has some of the worst infant mortality, infant morbidity, and low birthweight statistics in the Nation. The Committee also recognizes the presence of high quality universities in the rural Midwest, particularly in the State of Iowa.

The Committee has been pleased with various Health and Human Services research initiatives in sudden infant death syndrome [SIDS], and believes that efforts should extend to maternal and child health service activities. The Committee directs the Bureau, as a first step toward addressing this problem which accounts for the deaths of 7,000 to 8,000 infants each year, to conduct a comprehensive national needs assessment of available SIDS services. The Bureau should work closely with voluntary and professional organizations concerned with SIDS. The assessment should serve as a focal point for continuing and future departmental activities and initiatives.

The Committee is concerned about the growing problem, particularly in urban areas, of babies being born addicted to drugs and/or infected with the human immunodeficiency virus [HIV]. While the problem is especially acute in large urban areas, smaller communities also are confronted with this problem. For example, the number of drug-affected babies in Oregon rose from 64 in 1985 to 532 in 1989, an increase of over 700 percent. The Committee is aware of the Department's decision to require States, beginning in fiscal year 1991, to earmark at least 30 percent of their grant for services to children with special health care needs. An additional earmark of 30 percent will be required for preventive and primary health services to children. The Committee urges the Department to continue to take steps to reduce infant mortality in general and encourage States to develop and expand prevention strategies in order to reduce the number of babies born to mothers who are drug abusers or HIV infected in particular.

The Committee is aware that nearly 15 percent of all U.S. children have a chronic health condition, with about 1 million children suffering a severe chronic condition. To facilitate effective delivery

of services to these children, information regarding service availability must be readily accessible to parents and practitioners.

Recognizing this fact, Congress enacted section 505(a)(5)(E) of the 1989 amendments to title V of the Public Health Service Act, directing States to establish a toll-free number for the use of parents to access information about health care providers.

However, as a June 1989 GAO study noted, a national clearinghouse is needed to enhance and coordinate the information available through the States. Therefore, the Committee urges the Bureau to establish a national information and referral system for chronically ill children. This system should provide a toll-free number for parents and health care practitioners to learn of programs available nationwide for the treatment of chronically ill children. Consistent with the GAO report, the Committee encourages that the system be established in linkage with the existing National Information System currently housed in Columbia, SC.

The Committee continues to be concerned that the pressing maternal and child health needs of American Samoan families are not being adequately met, primarily for cultural reasons. Last year the Committee directed MCH to initiate a program addressing this native American group, noting that in Hawaii, 74 percent of all women with live births received prenatal care during the first trimester, yet only 42 percent of Samoan women received the same level of care. Similar problems are evident in the area of teenage pregnancy, with the rate of American Samoans being 5.2 per 1,000, versus 3 per 1,000 for the general population. The Committee urges the Department to increase efforts targeted toward American Samoan families.

The Committee is pleased at the development of an early intervention demonstration project to initiate home- and center-based care for American Indian children. Public Law 99-457 provided incentives for States to plan and implement family based early intervention services for at-risk and handicapped children from birth to age 3, but development of these programs for American Indians on reservations remains far behind the general population. The GAO found a significant number of handicapped Indian preschoolers may be underserved, largely due to personnel shortages and inadequate funding. Therefore, the Committee recommends that a 5-year demonstration project be initiated with center- and home-based components to address this need in fiscal year 1991. The Committee is impressed with the initial efforts of Utah State University in working with the Navajo Nation and the States of Utah, Arizona, and New Mexico to develop culturally competent and developmentally appropriate early intervention services for handicapped Indian children.

Section 6509 of the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239 authorizes creation and distribution of a maternal and child health handbook. The Committee considers the MCH handbook to be an important project with the potential of improving the health of pregnant women and their children, and is pleased that the Secretary is proceeding with its development.

The Committee included \$1,000,000 in fiscal year 1990 to fund the MCH handbook. The Committee urges the Bureau to fund dis-

tribution of the handbook through SPRANS, and looks forward to receiving the handbook in fiscal year 1991.

The Committee recognizes the need for States to develop a uniform data system in order to conduct needs assessments and evaluations. These will enable the States to target resources more effectively and assess the impact on maternal and child health. Omnibus Budget Reconciliation Act of 1989 requires States to prepare an annual report beginning in fiscal year 1991 that contains detailed information the status of maternal and child health, health providers, and on the possible duplication of services under title V and the State Medicaid plan.

The Committee recommends that HRSA cooperate with States and with groups and organizations concerned with maternal and child health and Medicaid in developing a uniform information system for States to use. The Committee directs HRSA to use SPRANS funding to implement this requirement.

Pediatric emergency care

The Committee has included \$5,000,000 to continue the pediatric-EMS initiative. This is \$1,053,000 more than the fiscal year 1990 appropriation. The budget requested no funds for this activity, and the House provided none.

Pediatric EMS projects demonstrate the effectiveness of a systems approach to prehospital emergency care, including prompt, appropriate onsite assessment and treatment of the child's problem together with rapid, safe transport to an appropriate medical facility.

The Committee again expresses its strong interest in having at least one demonstration site address the unique problems of rural America, as well as one primarily addressing mental health issues.

Organ transplants

The bill includes \$3,457,000 for HRSA organ transplant activities. The amount provided is \$491,000 less than the fiscal year 1990 appropriation, \$800,000 less than the House amount, and \$200,000 above the budget request.

These funds support development of a scientific registry of organ transplant recipients and kidney dialysis patients, leading to evaluation of the scientific and clinical status of organ transplantation. The funds also extend the national network to match donors and potential recipients of organs. A portion of the appropriated funds may be used for education of the public and health professionals about organ donations and transplants, and to support agency staff providing clearinghouse and technical assistance functions.

The Committee recommendation includes \$1,384,000 to continue the development of the scientific registry of organ transplant recipients, including the funding of studies by the registry; \$1,382,000 for the organ procurement and transplantation network; and \$691,000 to operate HRSA's Division of Organ Transplantation. Ten full-time equivalents, including at least 3 with substantial expertise in the area of organ retrieval and distribution, will be supported by the funds provided.

The Committee encourages the Division to support a system to provide information to patients, their families, and their physicians

about the resources available nationally and within each State to assist a family with the costs associated with organ transplantation, and the comparative costs and patient outcomes at each transplant center affiliated with the organ procurement and transplantation network.

Health teaching facilities interest subsidies

The Committee recommends \$488,000 for interest subsidies for three health professions teaching facilities. This is the same as the fiscal year 1990 appropriation, the House allowance, and the administration's budget request.

BUILDINGS AND FACILITIES

The Committee recommends \$2,000,000 for maintenance and repairs to facilities at the Gillis W. Long Hansen's Disease Center. This is \$1,123,000 more than the fiscal year 1990 appropriation, the same as the House amount, and \$2,000,000 more than the budget request.

This funding will provide for routine repairs and improvements to ensure the continued safe and efficient operation of the center located at Carville, LA.

NATIONAL PRACTITIONER DATA BANK

The Committee has provided \$1,974,000 for the national practitioner data bank, which is the same as the fiscal year 1990 amount and the House allowance. The administration requested no funds for fiscal year 1991. In addition, user fees collected by the data bank are used for the operation of the data bank.

The data bank was created by Public Law 99-660, to serve as a national source of information on malpractice judgments and settlements and various other disciplinary actions taken against physicians, dentists, and other categories of licensed health professionals.

The Committee concurs with the House Committee in its concern over the cost-efficiency and internal security of the data bank. The Committee supports continuation of the data bank, provided these concerns are addressed by the Secretary. The Committee also concurs with the House Committee in encouraging that batched inquiries be accommodated by the data bank.

RURAL HEALTH RESEARCH

The Committee recommends \$5,500,000 for HRSA's Office of Rural Health Policy. This amount is \$1,120,000 more than the House amount, \$2,120,000 over the fiscal year 1990 appropriation, and \$1,120,000 more than the budget request.

The funds provided will support the Office as the focal point for the Department's efforts to improve the delivery of health services to rural communities and populations.

Of the amounts provided, the Committee recommends \$2,200,000 for the seven rural health research centers. The Committee encourages the Office to disseminate the research findings of the centers by cooperating with the information dissemination branch of the

Agency for Health Care Policy and Research. The remaining funds include \$2,000,000 to begin a program of grants to State offices of rural health, \$400,000 to support the National Advisory Committee, and continued funding for the MEDNET project, other ongoing projects, and the office.

Because of the difficulty in accessing current rural health information, the Committee strongly supports the Office's support of national rural health publications to disseminate information and current research. The Committee strongly urges the office to increase its support of this important activity. The Committee commends the Office's efforts to hold informational conferences, such as the recent conferences on State Offices of Rural Health and AIDS in rural areas.

The Committee requests that the Office furnish a report detailing its activities regarding efforts to disseminate information on rural health clinics, the activities of the rural health research centers, and the progress of the rural health information clearinghouse to date. The report should address how the rural health clearinghouse may be coordinated with the Agency for Health Care Policy and Research's, information dissemination activities. The Committee further requests that the Office furnish directly to the Committee any reports issued by the Secretary's Advisory Committee on Rural Health.

In order to increase the capability of the Office to respond to its statutory mandate to provide impact analyses of proposed Medicare and Medicaid regulations, the Committee has directed the Prospective Payment Assessment Commission to provide support services to the Office.

ACQUIRED IMMUNE DEFICIENCY SYNDROME [AIDS]

The Committee has included \$617,500,000 for AIDS/HIV programs, including those authorized by the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. This amount is \$509,783,000 more than the comparable fiscal year 1990 appropriation, \$540,134,000 more than the House provided, and \$549,607,000 more than the administration request.

Emergency assistance

The Committee recommends \$300,000,000 for emergency assistance grants to 16 high-impact metropolitan areas. Of this amount, \$49,000,000 is available immediately, with an additional \$251,000,000 to be available for obligation October 1, 1991. These funds will be provided to metropolitan statistical areas with more than 2,000 AIDS cases, and to metropolitan areas that have a per capita incidence of cumulative cases of AIDS equal to or greater than 250 per 100,000 population, as reported by CDC.

Comprehensive care programs

The Committee has provided \$300,000,000 for AIDS health care services authorized by title II of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. Of this amount, \$190,000,000 shall be available for obligation October 1, 1991.

The Committee is pleased with the progress that State and local grantees have made in coordinating health care services for AIDS patients through the various service demonstration projects administered by HRSA. These include HRSA's AIDS Drug Reimbursement Program and the State and local grant programs for adult and pediatric care demonstrations, home health and subacute care services, and community health care services. The Committee has provided funding in fiscal year 1991 to continue the current level of services now provided through existing grantees. To ensure the uninterrupted service of these grantees, the Committee has included bill language mandating that these successful programs will be continued under the new authorities, and ensuring that no State or current grantee would receive less funds to maintain these programs in fiscal year 1991 than it received in fiscal year 1990.

The Committee has provided an advance appropriation of \$190,000,000 to become available on October 1, 1991. This should provide sufficient time for States to work with localities, AIDS service providers, and other eligible entities and interested parties to craft State plans, as required by the Ryan White Comprehensive AIDS Resources Emergency Act of 1990.

Under the act, the current HIV Services Program, the AIDS pediatric health care demonstration grants, the home- and community-based health care grants, and the AIDS Drug Reimbursement Program will be replaced with a HIV Services Formula Grant Program.

The HIV Services Formula Grant Program will allow the States to develop the following areas of emphasis: (1) service demonstration programs for high-impact areas; (2) selected HIV services planning activities to lower-incidence communities; (3) service system design grants for moderate-incidence communities; (4) development and demonstration of new models of early intervention; (5) home and community-based services; (6) services for women, children, and families with HIV infection; (7) drug reimbursement services; and (8) technical assistance to HRSA AIDS-related programs. Current grantees under the HIV Service Demonstration Program would continue to receive funding from the State's allotment until the completion of their approved project periods, after which time all funds available to these grantees would be allocated to the States and territories by formula.

Each State and territory will receive a minimum grant, with remaining funds distributed based on a formula that includes the number of AIDS cases diagnosed and reported for a given period as well as an adjustment of up to 25 percent based on per capita income. States will also be required to provide funds to match Federal funds used for AIDS drug reimbursement. States are entitled to allocate funds among the eligible activities in accordance with local needs and priorities.

This program will allow the States to address their needs for delivery system development, drug reimbursement, and home care alternatives for their HIV-infected populations, and coordinate services for children and women of child-bearing age with HIV infection, AIDS, or other related conditions. The expanded authority will provide States and cities with funding to implement plans already completed, develop systems of care in cities greatly affected

by the epidemic but not yet able to develop a service system, and develop monitoring protocols and risk-behavior counseling programs for asymptomatic patients. The formula grant will help assure the availability of coordinated systems of community-based care, and provide for the special needs of the mildly symptomatic. By encouraging development of a wide range of alternatives to inpatient hospital care including outpatient early intervention programs, this formula grant program should help reduce unnecessary hospital admissions and excessive lengths of stays and thereby help reduce the cost of care for infected people.

Each State should establish a health planning council, with appropriate provider and community representation, to set priorities for allocating funds within the State.

Up to 10 percent of the total formula grant budget may be used to establish a program of special projects of national significance. These direct grants to States, localities, or community-based organizations will fund special programs for care and treatment of individuals with HIV disease. These might include supplemental grants to enhanced State service delivery models, or contracts with nationally recognized AIDS organizations or individuals to provide assistance to local community-based organizations with problems related to the delivery of health services to HIV-infected individuals.

The Committee recognizes the importance of maintaining an appropriate range of family-centered services for infants, children, women, and families with HIV diseases. Therefore, the Committee encourages the Secretary, through the Bureau of Maternal and Child Health, to provide all appropriate technical assistance to States, localities, and eligible entities as they craft State plans and implement the provisions of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990.

The Committee is extremely concerned about the availability of mental health services for persons with AIDS. Such services may be integral to preventing further transmission of the virus, improving the quality of life, and reducing morbidity and mortality, as well as related health care costs. The Committee also recognizes the importance of oral health care to HIV-positive individuals and is aware that, in many communities, dental schools have provided much of the dental care for AIDS patients, often without compensation. It is the Committee's belief that States and territories should include representatives of local dental schools and mental health providers in the process of crafting State plans, as required under the act.

AIDS education and training centers

The Committee recommends \$17,500,000 for AIDS education and training centers [ETC's], authorized under sections 301 and 788(a) of the Public Health Service Act. This amount is \$2,951,000 over the fiscal year 1990 amount, the same as the House amount, and \$3,500,000 below the budget request.

AIDS ETC's offer specialized training to health care personnel who care for AIDS patients. These projects train health care practitioners, faculty, and students, the staff of federally funded health care facilities, and support development of curricula on diagnosis

and treatment of HIV infection for health professions schools and training organizations. These funds are available for new or continuation awards under section 301 or 788B(a) of the Public Health Service Act.

Over 2 million primary health care providers and community service workers need to be prepared to deal with the physical, social, and psychological impact of AIDS. Furthermore, staff of health care facilities and students in the health professions must learn about the care, treatment, and counseling of AIDS patients and HIV-infected individuals.

Facilities renovation

The Committee has provided \$4,000,000 for facilities renovation, which is \$129,000 less than the administration request and the House allowance, and \$342,000 below the fiscal year 1990 amount. These grants support development of nonacute care facilities for AIDS patients.

PROGRAM MANAGEMENT/PROGRAM SUPPORT

Program management and direct operations

The Committee recommends \$104,551,000 for HRSA program management and direct operations activities for fiscal year 1991, including AIDS. This is an increase of \$5,000,000 over the administration's request, \$2,551,000 over the House amount, and \$6,381,000 over the fiscal year 1990 appropriation level.

The Committee has restored to HRSA numerous programs the administration's budget request omitted, and therefore has provided the necessary increase in program management funds. It is the Committee's expectation that the administration will use all resources provided to conduct those functions.

MEDICAL FACILITIES GUARANTEE AND LOAN FUND

Appropriations, 1990	\$21,000,000
Budget estimate, 1991	20,000,000
House allowance	20,000,000
Committee recommendation	20,000,000

The Committee recommends \$20,000,000 for the medical facilities guarantee and loan fund. This is the same as the administration's request and the House amount, and \$1,000,000 less than the fiscal year 1990 appropriation. These funds are used to comply with the obligation of the Federal Government to pay interest subsidies on federally guaranteed loans throughout the life of the loans. These loans were used for hospital modernization, construction, and conversion.

HEALTH EDUCATION ASSISTANCE LOANS [HEAL]

The HEAL Program is a major source of non-Federal funds to thousands of health professions students pursuing health careers. The Committee directs that loan guarantee funds under the HEAL Program in fiscal year 1991 be available without regard to any apportionments or other administrative limitations not specifically authorized by statute.

Committee requests a report on the progress the Agency has made in this direction and future prospects.

The Committee recognizes the importance of assessing the effectiveness of mental health treatment, especially for children. There is a great need to improve the quality and cost effectiveness of these services. In particular, research needs to be conducted that helps better define the quality and appropriateness of treatment and how these relate to outcomes, including functioning and symptomatology. The Committee encourages AHCPR to support such research.

HEALTH CARE FINANCING ADMINISTRATION

GRANTS TO STATES FOR MEDICAID

Appropriations, 1990	\$40,229,502,000
Budget estimate, 1991	44,901,509,000
House allowance	45,014,966,000
Committee recommendation	47,281,301,000

The Committee recommends \$47,281,301,000 for grants to States for Medicaid. This amount is \$7,051,799,000 more than the fiscal year 1990 appropriation, \$2,266,325,000 more than the House allowance, and \$2,379,792,000 more than the administration's request. This amount includes \$10,400,000,000 appropriated in fiscal year 1990 as an advance for fiscal year 1991, and reflects the latest current law estimates. The higher estimates reflect the administration's midsession review, due primarily to more participation than previously estimated, as well as higher average outlays per participant.

The Medicaid program provides medical care for eligible low-income individuals and families. It is administered by each of the 50 States, the District of Columbia, Puerto Rico, and the territories. Federal funds for medical assistance are made available to the States according to a formula which determines the appropriate Federal matching rate for State program costs. This matching rate, which may range from 50 to 83 percent, is based upon the State's average per capita income relative to the national average.

Each State Medicaid program must provide a basic package of medical services, including inpatient and outpatient hospital care, health screening services for children under 21 years of age, skilled nursing facility care for persons 21 years of age or older, and physician services.

The Committee has provided an advance appropriation of \$13,500,000,000 for the first quarter of fiscal year 1992. This recommendation reflects the latest available current law estimates.

The Committee recommendation includes \$28,364,000 for Medicaid State certification activities. The administration requested no appropriation for these activities, and instead proposed to finance all costs of the State certification program through the collection of user fees.

The Committee has included the administration's user fee proposal, but has retained sufficient Federal funding through January 1, 1990, 3 months beyond the administration's request, in recognition of the fact that startup funding must be provided in the initial

stages of the program. The Committee takes this action due to severe budget restraints. Together with funds in the "Program management" account, a total of \$308,011,000 in direct outlays would have to be added to the President's request, in order to reject the user fee proposal. The Committee has included \$76,255,000 to delay the impact of this proposal for the first 3 months of fiscal year 1991.

Reports have reached the Committee that State Medicaid programs are refusing to reimburse providers for early intervention and related services under the Education of the Handicapped Act to Medicaid-eligible low income children. Section 1903(c) of the Social Security Act, as amended by Public Law 100-360, states that nothing in title XIX—Medicaid shall be construed as prohibiting or authorizing the Secretary to prohibit education programs under part B or in an individualized family service program under part H of the Education of the Handicapped Act. Moreover, restrictions in Medicaid law prohibiting the use of Medicaid funds to cover the cost of services provided to the public free of charge do not conflict with the policies set forth in section 1903(c). So long as public and private service providers comply with established Medicaid procedures, Medicaid cannot prohibit payment for covered services furnished to a handicapped child, infant, or toddler. The Committee directs the Departments of HHS and Education to develop a joint policy statement containing consistent information and uniform procedures to enable Medicaid, part B and part H agencies and health care providers to work together in helping children, infants, and toddlers with disabilities obtain the full benefits of Federal programs. The agencies are to inform the Committee of the actions they take to implement the law.

PAYMENTS TO THE HEALTH CARE TRUST FUNDS

Appropriations, 1990.....	\$36,338,500,000
Budget estimate, 1991.....	37,056,000,000
House allowance.....	37,056,000,000
Committee recommendation.....	35,335,000,000

The Committee recommends \$35,335,000,000 for payments to the health care trust funds. This amount is \$1,003,500,000 less than the fiscal year 1990 appropriation, and \$1,721,000,000 less than the House allowance and the administration's original request.

The Committee recommendation is consistent with the latest current law estimates for the three mandatory activities which comprise these payments: supplementary medical insurance, hospital insurance for the uninsured, and the Federal uninsured payment.

The Committee has provided \$34,730,000,000 for payment to the supplementary medical insurance trust fund. This amount provides matching funds for premiums paid by Medicare part B enrollees. The reduction reflects midsession review technical reestimates of such factors as physician and outpatient services and lower rates of growth in SMI enrollment.

The recommendation includes \$559,000,000 for hospital insurance for the uninsured. This amount is the same as the administration's request, and \$181,000,000 more than the fiscal year 1990 appropriation. This payment reimburses the hospital insurance trust fund

for Medicare benefits to individuals who have not met the necessary requirements for insured status.

The recommendation also includes \$46,000,000 for the Federal uninsured benefit payment. This amount is the same as the administration's request, and \$11,000,000 more than the fiscal year 1990 appropriation. This payment reimburses the hospital insurance trust fund for the cost of benefits provided to Federal annuitants now eligible for Medicare.

PROGRAM MANAGEMENT

Appropriations, 1990	\$100,552,000
Budget estimate, 1991	90,079,000
House allowance	104,966,000
Committee recommendation	91,053,000

The Committee recommends a Federal funds appropriation of \$91,053,000 for Health Care Financing Administration [HCFA] program management. This amount is \$974,000 more than the administration's request, \$13,913,000 less than the House allowance, and \$9,499,000 less than the fiscal year 1990 appropriation.

This recommendation is in addition to \$1,901,888,000 in trust funds. This trust fund amount is \$87,917,000 more than the administration's request, \$124,750,000 less than the House allowance, and \$57,026,000 more than the comparable fiscal year 1990 appropriation.

Research, demonstration, and evaluation

The Committee has provided \$72,000,000 for HCFA research, demonstration, and evaluation activities. This amount is \$36,000,000 more than the administration's request, \$3,000,000 more than the House allowance, and \$22,000,000 more than the fiscal year 1990 appropriation.

HCFA research and demonstration activities facilitate informed, rational Medicare and Medicaid policy analysis and decisionmaking. These studies and evaluations include projects to measure the impact of Medicare and Medicaid on health care costs, and to develop alternative strategies for reimbursement, coverage, and program management.

The recommended funding level will provide for both the continuation of current activities and the startup of new projects. Priority areas for HCFA research include quality of care, physician payment systems, and preventive care. A large percentage of HCFA research, demonstration, and evaluation activities is mandated by the Congress.

The Committee has included \$25,000,000 to continue the Rural Health Care Transition Grant Program. This is \$7,239,000 more than the fiscal year 1990 appropriation and \$2,000,000 more than the House allowance. The administration did not request fiscal year 1991 funding for this program. Designed to help small rural hospitals adjust to the changing health care environment, this program was initiated in fiscal year 1989 and is authorized through fiscal year 1992. The Committee expects a portion of these funds to be used for third-year continuation grants.

The Committee recommends \$10,000,000 to initiate the recently authorized Essential Access Community Hospitals/Rural Primary Care Hospitals [EACH/RPCH] Program. The House also recommended \$10,000,000 for which there was no budget request. The program provides grants to States to plan and implement a rural health care plan and rural health network. It also provides grants to hospitals and facilities up to \$200,000 for the costs of converting to essential access or rural primary care hospitals.

The Committee has provided \$500,000 for bridge funding for the New Jersey respite care demonstration project. This project was defined in section 9414 of the Omnibus Budget Reconciliation Act of 1986 as a 4-year demonstration project. Because of delay in implementation, the program has only been operational for 2 years on its expiration date of October 1, 1990. It currently provides valuable respite care services to 2,000 families in the State of New Jersey. The evaluation phase of the program will not be completed until after the fourth year of funding expires. The sum provided is intended to continue the program until technical changes in the authorizing legislation can be enacted so that funding can be arranged to complete the full 4-year demonstration.

The Committee is concerned with increasing numbers of complaints from Medicare beneficiaries and providers in rural and other medically underserved areas about the adverse effect of Medicare regulations on access to and quality of health care services. The Secretary should, therefore, undertake a review of Medicare rules and regulations imposed on providers and beneficiaries in these areas to determine which are unnecessary or could be made less administratively burdensome while maintaining or improving the quality of care provided.

The Committee is also concerned that Medicare's process for developing rules and regulations does not adequately take into account local and regional differences. The Committee is aware of complaints regarding the adequacy of beneficiary and provider input into the rulemaking process. The Secretary should, therefore, consider conducting a demonstration project to test the feasibility of applying a regionalized approach to developing guidelines and carrier instructions with respect to one or more Medicare reimbursable services. The demonstration project should assess the impact of a regionalized approach on the accessibility, cost, and quality of the service or services in question.

Alzheimer's disease

While considerable data exists on the long-term care experiences of the elderly and disabled, there is a shortage of information on victims of Alzheimer's disease and related disorders. As Congress develops proposals to address the long-term care crisis, it is critical that information on the most frail and dependent elderly—those suffering from cognitive impairments such as Alzheimer's disease—be readily available. Information is needed on the duration of Alzheimer's disease, from onset to death or, more specifically, on the duration of caregiving in the home and in community-based settings, and the length of stay in nursing homes. The costs of care for dementia patients, such as outlays for incontinence supplies, in-home and community services, lost work hours and wages for care-

givers, and nursing home costs also are vital but absent pieces of information on a national level. The Committee has provided an additional \$1,000,000 to conduct analyses of existing State and national data, and to collect original data where needed, to provide information on a national basis on the duration of Alzheimer's disease and related disorders, the duration of the caregiving experience, and the costs of care.

Medicare contractors

The Committee recommends \$1,598,000,000 for Medicare contractors. This amount is \$15,000,000 more than the House allowance and the administration's request, and \$143,986,000 more than the comparable fiscal year 1990 appropriation. This recommendation provides for a \$136,500,000 contingency fund, the same as the House, to meet unanticipated operating costs.

The Medicare contractors, usually insurance companies, are responsible for reimbursing Medicare beneficiaries and providers in a timely and fiscally responsible manner. These contractors also provide information, guidance, and technical support to both providers and beneficiaries.

The Committee has provided operating funds of \$15,000,000 more than the administration's request in order to meet workloads underestimated in the administration's fiscal year 1991 projections, as well as to enhance payment safeguard activities.

The Committee requests that the Health Care Financing Administration report to the Committee by February 1, 1991, on the actual increase in claims volume for the first quarter of fiscal year 1991 and provide a revised projection of Medicare workload for the remainder of the fiscal year. The Committee also requests that the report contain a description of the difference between the administration's original budget request for fiscal year 1991 and any revised funding requirements based on the new workload estimates. It is further requested that the report provide a projection of any fiscal year 1991 backlogs of unpaid claims and the estimated cost of mandatory interest payments to be made on the late claims. Finally, the report should provide a statement of the actions taken to release any contingency funds needed to maintain current services levels of performance in the administration of the Medicare Program.

The Committee has heard reports from all over the country concerning discrepancies in coverage decisions among Medicare carriers, particularly with respect to payment for so-called unlabeled indications of drugs approved by the Food and Drug Administration. Both FDA and the Health Care Financing Administration recognize that medically appropriate uses of these drugs beyond the FDA-approved label should be reimbursed, yet individual carriers continue to deny payment in many cases. The result is both inefficient and inequitable. In particular, cancer patients are disadvantaged by this policy because their treatment relies heavily on the use of unlabeled indications. The Administrator of the Health Care Financing Administration should take steps without delay to render coverage decisions by Medicare contractors that correct this inconsistency. At least with respect to decisions on drug coverage, the contractors should be guided by the major medical compendia,

which are periodically updated to recognize appropriate new indications.

State survey and certification

The Committee recommends \$40,111,000 for HCFA State survey and certification activities, an amount which will support these activities for one fiscal quarter in fiscal year 1991. This recommendation is \$57,572,000 less than the fiscal year 1990 appropriation. The administration requested no fiscal year 1991 appropriation for these activities, and instead proposed to finance all costs of the State certification program through the collection of user fees. The Committee believes that sufficient startup funding must be provided to cover the costs of State certification activities during the initial stages of the user fee program. As indicated in the Medicaid section of this report, the Committee action was taken primarily due to budgetary restraints.

This recommendation includes a \$1,336,000 direct appropriation for State certification program support, \$5,133,000 less than the fiscal year 1990 appropriation, due to the transition to user fees.

Federal administration

The Committee recommends \$75,717,000 in Federal funds and \$207,113,000 in trust funds for a total of \$282,830,000 for Federal administration. This recommendation assumes the collection of \$248,000 in Health Maintenance Organization user fees. The recommendation is \$2,220,000 less than the administration's request, and \$60,887,000 less than the fiscal year 1990 appropriation. The Committee recommendation includes \$10,000,000 in administrative costs below the budget request. This reduction is intended to make HCFA operate more efficiently with a smaller administrative staff than the 4,127 requested positions.

The Committee believes that HCFA should take action to streamline unnecessarily burdensome paperwork requirements imposed on both providers and beneficiaries. Reducing paperwork should not only save administrative costs, but should increase the quality and level of services by allowing a greater proportion of health care professionals time to be spent on direct patient care. The Committee believes proper regulations are essential to assuring high quality service to Medicare and Medicaid beneficiaries, but expects them to be carried out in a more effective manner, taking fuller account of the views and needs of beneficiaries and providers.

The Committee has provided \$7,780,000 for Federal administration associated with Medicare and Medicaid State certification activities, of which \$6,143,000 is trust funds. The administration requested no fiscal year 1991 appropriation for these activities, and proposed instead to fund all survey and certification activities and associated administrative costs through the collection of user fees. The House rejected the user fee proposal, providing \$31,118,000 for Federal administrative costs related to State certification activities, of which \$24,567,000 is trust funds. The Committee recommendation has provided the necessary funding to cover costs during the initial stages of the user fee program.

Through fiscal year 1991, HCFA will have spent more than \$100,000,000 on development and operation of the common working

file [CWF] project, an ADP system initiative designed to improve Medicare claims processing. A July 1990 GAO report indicated that HCFA has not supported this project's benefits to the Medicare Program, primarily because it did not pay attention to well-established Federal guidelines that describe the steps and documentation required to initiate and develop an ADP project. Among the critical steps that HCFA did not follow was the consideration of alternative solutions to its information problem and preparation of thoroughly documented support for CWF's estimated benefits. In addition, the cost of this project continues to increase as HCFA has scheduled about \$11,000,000 in system enhancements, many basic to CWF's operation, for fiscal year 1991. Because of this project's uncertain benefits and its increasing cost to develop, the Committee is concerned about implementation of this project. As a result, the Committee is requesting that HCFA provide evidence of CWF's benefits. This support, which should be submitted to the Committee by February 1, 1991, should include a description of the resulting benefits from actual CWF operations. In addition, the Committee would like further details from HCFA by December 1, 1990, on the planned \$11,000,000 in expenditures it has requested for fiscal year 1991. The expenditure information should identify how the money will be spent and what benefits are to be achieved from these expenditures.

Clinical Laboratory Improvements Act [CLIA]

The Committee is concerned that the Department of Health and Human Service's implementation of the Clinical Laboratory Improvements Act of 1988 may unnecessarily jeopardize access to essential lab services, especially in rural areas. The Committee believes that significant action by HCFA is necessary to assure that the design and intent of CLIA are fully carried out.

First, the Committee is concerned that the Department has not completed any of the five studies required by CLIA. One of the studies of particular concern was to examine the relationship between personnel standards and accuracy of test results. The Secretary, acting through the Public Health Service, was directed to study the correlation between established standards for personnel employed in clinical laboratories and the accuracy and reliability of the results of the tests performed by the laboratories which are subject to such standards. The results of this study, along with four others, were to be reported to Congress no later than May 1, 1990. The Committee directs the Secretary to immediately provide the Congress with a summary of actions taken to date to complete these studies and calls upon him to complete the studies without further delay.

Second, the Committee is concerned with a number of provisions of the regulations proposed by the Health Care Financing Administration to implement CLIA. The Committee believes that the proposed regulations relating to personnel requirements may have a significant adverse impact on access to laboratory services available to patients, especially those residing in rural and underserved areas. We are, therefore, concerned that the regulations be made reasonable, fair, and reflective of the most current data and analysis available. In providing the Secretary discretion to set strength-

ened personnel standards, Congress did not intend to limit patient access to care or place an undue burden on providers. The Committee believes that in developing personnel standards, the Secretary, utilizing the most current data and analysis available, shall take into consideration the costs associated with such standards including the impact on the timely delivery of test results to patients and the impact on the ability of health care facilities to continue to provide other health care services. The Committee believes that HCFA should be guided by these principles in finalizing regulations not only in this area, but all others as well.

Among the steps that might be taken to address the shortage of properly credentialed laboratory personnel, the Committee urges the Secretary to consider using his authority to reinstate the HHS proficiency exam for this purpose only. If done appropriately, this would help to expand the pool of qualified laboratory technologists in shortage areas while assuring improved quality protections. It may, of course, be necessary, with the cooperation of the appropriate professional associations, to update or refine the exam to assure maximum quality.

The Committee has also received numerous complaints regarding the proposed regulations' classification of basic tests. The Committee urges that final regulations in this area be constructed to assure that prompt access to accurate test results is not diminished and take into consideration the comments of concerned providers and others.

In order to provide sufficient opportunity for review and consideration of revised regulations, the Committee directs HCFA to provide a public review and comment period of not less than 60 days subsequent to publication of the revised regulations. During that public comment period, it is expected that the Committee on Labor and Human Resources will hold oversight hearings on the regulations which shall include not only HCFA but also the Public Health Service. These actions will provide Congress an opportunity to consider further action as may be necessary.

Finally, the Committee believes that the long overdue CLIA regulations must be appropriately revised and implemented. CLIA was approved in Congress with bipartisan support because of evidence that the performance of many laboratories is not what it should be to assure quality testing for all patients.

The Committee intends that funds from the "Program management" account be available to cover the costs of promulgation of the final regulations of the Clinical Laboratory Improvement Amendments of 1988. The Committee does assume that user fees for certification of clinical laboratories shall be collected under section 353 of the Public Health Service Act. Such user fees shall then be available within the "Program management" account until expended.

SOCIAL SECURITY ADMINISTRATION

PAYMENT TO SOCIAL SECURITY TRUST FUNDS

Appropriations, 1990.....	\$191,968,000
Budget estimate, 1991.....	46,958,000
House allowance.....	46,958,000
Committee recommendation.....	46,958,000

The Committee recommends an appropriation of \$46,958,000 for payments to Social Security trust funds, the same as the administration request and the House allowance. The recommendation is \$145,010,000 less than the fiscal year 1990 appropriation of \$191,968,000.

These funds reimburse the old-age and survivors insurance and disability insurance trust funds for special payments to certain uninsured persons, costs incurred administering pension reform activities, and the value of the interest for benefit checks issued but not negotiated. This appropriation restores the trust funds to the same financial position they would have been in had they not borne these costs, properly charged to the general funds.

The fiscal year 1991 appropriation decrease reflects the implementation of Public Law 100-86 which credits the value of unnegotiated checks directly to the trust funds from Treasury's general fund rather than through this appropriation. This appropriation continues to fund interest lost to the trust funds on unnegotiated checks. The fiscal year 1991 appropriation also decreases because special payments for certain uninsured persons declines due to a declining beneficiary population.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

Appropriations, 1990.....	\$659,253,000
Budget estimate, 1991.....	626,081,000
House allowance.....	626,081,000
Committee recommendation.....	626,081,000

The Committee recommends an appropriation of \$626,081,000 for special benefits for disabled coal miners, which is in addition to the \$215,000,000 appropriated last year as an advance for the first quarter of fiscal year 1990. The recommendation is \$33,172,000 less than the comparable fiscal year 1990 amount of \$659,253,000 and the same as the House allowance.

These funds are used to provide monthly benefits to coal miners disabled by black lung disease and to their widows and certain other dependents, as well as to pay related administrative costs.

Social Security's major responsibility is for claims filed before June 1973, with the Department of Labor having responsibility for claims filed after that date. By law, increases in black lung benefit levels are tied directly to Federal pay increases. The year-to-year decrease in this account reflects a declining beneficiary population partially offset by a projected 3.5 percent benefit increase in January 1991.

The Committee recommends an advance of \$203,000,000 for the first quarter of fiscal year 1992, the same as the administration request and the House allowance.

SUPPLEMENTAL SECURITY INCOME

Appropriations, 1990.....	\$9,358,758,000
Budget estimate, 1991.....	11,998,594,000
House allowance	12,001,594,000
Committee recommendation.....	13,954,618,000

The Committee recommends an appropriation of \$13,954,618,000 for supplemental security income [SSI], which is in addition to the \$3,157,000,000 appropriated last year as an advance for the first quarter of fiscal year 1991. The recommendation, reflecting the administration's midsession review entitlement estimates, is \$4,595,860,000 more than the comparable fiscal year 1990 amount of \$9,358,758,000, \$1,956,024,000 over the original administration request, and \$1,953,024,000 more than the House allowance.

These funds are used to pay benefits under the SSI Program, which was established to ensure a Federal minimum monthly benefit for aged, blind, and disabled individuals, enabling them to meet basic needs. In many cases, SSI benefits supplement income from other sources, including Social Security benefits. The funds are also used to reimburse the trust funds for the administrative costs of the program with a final settlement by the end of the subsequent fiscal year required by law, support the referral and monitoring of certain disabled SSI recipients who are drug addicts or alcoholics and to reimburse State vocational rehabilitation services for successful rehabilitation of SSI recipients. The Committee understands that there have been delays in reimbursing the States; the Committee expects the Social Security Administration to reimburse the States for any legitimate entitlement costs which they are owed for successful rehabilitations under law.

The appropriation increases in 1991 because there were 11 monthly benefit payments in 1990 as compared to 12 in 1991. It also increases by \$2,000,000,000 to incorporate midsession review updates, primarily reflecting the impact of the Supreme Court decision in the *Zebley* case. This case, discussed further in the "Limitation on administrative expenses" account, requires that disabled children under SSI be evaluated on the basis of functional ability, as adults are, and applies retroactively. Additionally, there is a one-time increase in budget authority related to a change in the procedure for accounting for overpayments. The \$1,134,826,000 recommended for State administrative cost reimbursements to the trust fund represents a 4-percent inflationary increase over the fiscal 1990 enacted level.

The Committee recommends an advance of \$3,550,000,000 for the first quarter of fiscal year 1992, the same as the House allowance.

The Committee recommendation includes \$1,134,826,000 for State administration, an increase of \$44,695,000 over fiscal year 1990, but \$77,776,000 less than the budget request, representing an inflationary increase of about 4 percent.

The Committee recommends \$6,000,000 to maintain the Social Security Administration's outreach demonstration project, for which there was no budget request. The House included \$3,000,000 for these outreach activities. The Commissioner should continue to make grants and cooperative agreements with public or private, nonprofit organizations, and should replicate successful demonstra-

tion projects funded in fiscal year 1990. The Committee expects these additional funds to be targeted to poor populations with high levels of nonparticipation in the Supplemental Security Income Program, and in areas of limited accessibility due to rural location or language barriers.

The Committee understands that the Social Security Administration received more than 350 applications for funding for outreach projects and will be able to fund only a limited number of those applications in fiscal year 1990. The Committee urges SSA to use fiscal year 1991 funds to award grants to worthy applicants from the original group rather than conducting a new application process. This will guarantee that outreach projects to potential SSI beneficiaries are begun with the least possible delay.

The Committee notes that the GAO has urged that the outreach demonstration projects have a strong evaluation component designed in from the beginning. The Committee directs the Commissioner use no less than 5 percent of the appropriation for grants or contracts for an independent evaluation to determine the outreach approaches most effective in addressing systemic barriers to participation by potential SSI eligibles.

The Committee has included \$1,000,000 for a grant to be awarded to a nonprofit aging organization for the purpose of developing educational and public outreach materials on the Medicare program and Medigap insurance or Medicare supplemental policies. Written educational materials and pamphlets and taped public service radio announcements will be developed on the Medicare program including issues of coverage, benefits, appeal procedures, recent changes in law, carriers, and linkage to Medicaid. The educational outreach materials must also contain information to aid senior citizens in purchasing Medigap insurance, including coverage under specific policies and protection against fraud and abuse. Final materials developed by the grantee will be distributed by the grantee and the Department of Health and Human Services to the interested public including media, senior organizations, community service groups, and nonprofit local Medigap and Medicare counseling services.

LIMITATION ON ADMINISTRATIVE EXPENSES

Appropriations, 1990	(\$3,837,389,000)
Budget estimate, 1991	(4,166,974,000)
House allowance	(4,166,974,000)
Committee recommendation	(4,316,974,000)

The Committee recommends a limitation on administrative expenses of \$4,316,974,000, an increase of \$150,000,000 over the administration request and the House allowance. This is an increase of \$479,585,000 from the comparable fiscal year 1990 limitation amount of \$3,837,389,000.

This account provides resources from the Social Security trust funds to administer the Social Security retirement and survivors and disability insurance programs, and certain Social Security health insurance functions. As authorized by law, it also provides resources from the trust funds for certain nontrust fund administrative costs, which are reimbursed from the general funds. These

include administration of the Supplemental Security Income Program for the aged, blind, and disabled; work associated with the Pension Reform Act of 1974; and the portion of the annual wage reporting work done by the Social Security Administration for the benefit of the Internal Revenue Service. The dollars provided also support automated data processing activities and fund the State disability determination services which make disability determinations on behalf of the Social Security Administration.

The year-to-year increase is primarily to fund the built-in costs of maintaining Social Security staffing, disability State agency staffing, computers, telephones, facilities and related support services at current levels. These increases are driven by pay raises, within-grades, promotions, and increases for retirement benefits, health benefits, rent, postage, medical costs, printing, and supplies. Increases are also budgeted to improve service to the public through investments in technology, improvements in working conditions and training for SSA employees, and replacement of wornout equipment.

The Committee is aware that the February 1990 Supreme Court ruling in *Sullivan v. Zebley* will require a review of hundreds of thousands of previously denied cases to determine whether low-income children with disabilities were sufficiently impaired to be eligible for SSI benefits. The administration is urged to promptly submit a supplemental request of additional resources that are deemed necessary to expeditiously process these cases, conducting individual functional assessments required by the Court, without adversely affecting other Social Security operations. To avoid delay in reopening these cases, the Committee has increased the contingency reserve fund from \$50,000,000 to \$200,000,000 so that work may begin immediately pending determination of the full impact of this litigation on administrative costs.

The Committee recommendation includes \$25,000,000 more than the amount in the President's request to increase staffing levels by 1,500, to approximately 64,375 positions by the end of fiscal year 1991. The Committee expects this increase, which represents less than 10 percent of the additional amount provided over last year's level, to be accommodated within the overall limitation of \$4,316,974,000 recommended for fiscal year 1991.

Over the last 6 years, staffing levels at the Social Security Administration have declined by 17,000 full-time equivalent positions; overtime and temporary employment have declined by 4,600 work-years in this same time period. The Committee has sought to moderate this decline, citing the deterioration of the quality of services provided to an especially vulnerable clientele, including many poor, disabled, and elderly individuals, as well as plummeting staff morale that has resulted from the stress of overwork.

Now, it is necessary to begin restoring vital staff resources, to reduce client waiting times, improve telephone service, and minimize errors that are resulting in unnecessary outlays from social security trust funds.

To maximize resources available for staffing increases, the Committee expects agency management to vigorously pursue recommendations from GAO and the Inspector General's Office to achieve greater savings, in such areas as competitive contracting

for consultative medical exams under disability programs, and data processing and telecommunications.

The Committee expects SSA to continue its semiannual report, due in February and August, on the "Levels of Service Provided to Social Security Beneficiaries and the Public in General." As in previous years, the report should contain data regarding staffing, accuracy, workload, and processing times, as well as specifically addressing telephone accuracy and busy signal rates.

The Committee reiterates its position that no action be taken to close field, district, branch, or hearings and appeals offices.

The Committee recommends deferring \$5,000,000 requested by the Social Security Administration for data processing and telecommunications because the Committee is concerned that the budget request is not consistent with its office automation program funding needs identified for fiscal year 1991 and subsequent years by the Office Automation Program Office. Budget documentation supporting the budget request shows that the agency anticipates \$25,000,000 will be needed to support the office automation project through 1995. However, GAO found that the supporting documents understated by \$122,000,000 the amount of funds that will be needed to support the office automation project through fiscal year 1995. To help the Committee evaluate office automation funding needs for fiscal year 1991 and subsequent years, the Committee requests the Social Security Administration to provide a detailed analysis of plans and cost estimates for acquiring additional office automation equipment and services. The Committee recommends that funding for this project be deferred until the Social Security Administration provides this analysis.

In view of the absence of adequate support for the systems integration services project, the Committee recommends a reduction of \$6,000,000 from the budget request for data processing and telecommunications. In reviewing the budget request, GAO found that the Social Security Administration has not justified a systems integration services project involving current systems modernization and future agency strategic initiatives. The administration estimates it will cost \$6,000,000 in fiscal year 1991 and \$30,000,000 between fiscal years 1991 and 1995. The Committee is concerned that the Social Security Administration cannot guarantee the project will improve the management and planning of its modernization initiatives or that its actual cost will not be substantially higher or lower than the estimate.

The Committee concludes that the quality of the budget documentation provided by the Social Security Administration limits its usefulness in evaluating current and future automated data processing needs. The lack of credible documentation points out inadequacies in the Social Security Administration's approach to long-term planning for computer systems and information technology systems enhancements.

In October 1989, the SSA implemented a national toll-free 800 number in an attempt to increase the amount of service the agency provides to the public by telephone.

The Committee continues to receive complaints regarding the persistent busy signals, especially during peak times, that have plagued the 800 number service since the inception of the program.

These persistent busy signals are having a particularly negative impact on the elderly and handicapped who rely so heavily on these services.

In the Committee report accompanying H.R. 4404, the dire emergency supplemental appropriations bill for fiscal year 1990, the Committee urged the SSA to make available local office telephone numbers as an alternative to the 800 number service by listing local office numbers in telephone directories and providing these numbers to all callers of the 800 number service. The Committee was disturbed to learn that to date no action has been taken with regard to this recommendation. The Committee strongly reiterates its position that SSA make local office numbers available to all callers of the 800 number service and list these numbers in local telephone directories. The Committee feels that these steps are necessary in order to alleviate the persistent busy signal rates and to ensure that all callers have prompt, accurate, and courteous telephone service.

The Committee is very concerned that persons afflicted with chronic fatigue syndrome [CFS], who are qualified for Social Security disability benefits, continue to encounter a variety of difficulties in obtaining them. The Committee notes that SSA has not taken action called for in the past by the Committee to correct this situation. The Social Security Administration is directed to: (1) update its guidelines on CFS by including a wide range of current medical information on this illness such as the research definition developed by the Centers for Disease Control, (2) increase awareness of this illness by all staff involved in disability claims processing, and (3) provide a report to the Committee from the Commissioner, during the first quarter of the fiscal year, on Social Security Administration activities related to this illness.

The Committee urges the Health Care Financing Administration and the Social Security Administration to act cooperatively to establish a more comprehensive training program on Medicare for Social Security Administration service, claims, field, and teleservice representatives. The initial training program for new employees should be expanded to provide more detailed coverage of issues such as Medicare entitlement, benefit gaps, claims and appeal procedures, working with carriers and intermediaries, linkage to Medicaid and integration with Medigap insurance policies. Experienced employees should receive periodic update training focused on problem areas and changes in the law.

The frustrations faced by deaf persons in their attempts to handle Social Security matters by telephone have been expressed to the Committee. Many Social Security questions and communications cannot be handled by the general operator who staffs the Social Security 800-telephone devices for the deaf [TDD] line. These communications, which may involve specific questions regarding appointments, followups on documentation, or inquiries about additional information necessary for an application or other proceeding, can only be handled by the local caseworker responsible for a client's file. Currently, there is no way for the deaf client to gain direct access by telephone to this person. Additionally, written communications from local Social Security offices often require telephone followup by Social Security beneficiaries. Many letters

from Social Security include the local caseworker's voice telephone number, and instruct the recipient to telephone that number within a limited number of days.

In an effort to provide equal access to all citizens—including the deaf—the Committee has included startup costs of \$300,000, within the funds available, for the installation of TDD's in local Social Security offices for fiscal year 1991.

FAMILY SUPPORT ADMINISTRATION

FAMILY SUPPORT PAYMENTS TO STATES

Appropriations, 1990.....	\$8,992,552,000
Budget estimate, 1991.....	9,657,246,000
House allowance.....	9,657,246,000
Committee recommendation.....	10,172,346,000

The Committee recommends an appropriation of \$10,172,346,000 for family support payments to States, which is in addition to \$3,000,000,000 appropriated in fiscal year 1990 as an advance for the first quarter of fiscal year 1991. This appropriation is \$515,100,000 more than the administration's request and House allowance, and \$1,179,794,000 more than the fiscal year 1990 comparable appropriation of \$8,992,552,000.

Funding under this program supports grants to States for the Federal share of public assistance for the needy and for child support enforcement activities. The "Aid to families with dependent children" [AFDC] account is the largest of the assistance programs in this account. These dollars support children in need who have been deprived of parental support by the death, disability, or continued absence of a parent from the home, or the unemployment of the principal wage earner. Funds are also provided to cover the costs of child care both for welfare recipients who need this service to participate in State job opportunities and basic skills [JOBS] training programs and to provide transitional child care for welfare recipients who leave the rolls as a result of increased earnings. Unless child care is provided as necessary, States cannot require welfare recipients to participate in JOBS.

Other types of benefits provided under this appropriation include emergency assistance, assistance to destitute or ill Americans who have been repatriated, and assistance to adults in Puerto Rico and the territories. The Child Support Enforcement Program assists families by locating absent parents, establishing paternity, and enforcing support obligations to insure that children are financially supported by both parents. Grants made under this account also include funds for the Federal share of the costs States incur in administering these programs. The Committee recommendation, with one exception, is the same as the President's estimates of the amounts needed for these entitlement programs; assumed savings of \$35,000,000 from proposed regulatory changes are not included. The Committee recommendation includes \$10,521,000,000 for benefit payments under the aid to families with dependent children program and \$16,346,000 for payments to the territories.

For emergency assistance, the Committee has provided the administration's midsession review estimate of \$204,700,000. The

Committee recommendation also includes \$1,000,000 for repatriation and \$1,496,300,000 for State and local welfare administrative costs. Finally, as a result of the passage of the Family Support Act of 1988, the Committee recommendation also includes the mid-session review estimate of \$412,000,000 to meet the costs of JOBS child care, transitional child care, and child care licensing grants.

For child support enforcement, \$1,197,000,000 is included for State and local administration, these costs are offset by the Federal share of collections, estimated at \$1,008,000,000. In addition, Federal incentive payments of \$332,000,000, an increase of \$56,000,000 over fiscal year 1990, are provided.

The Committee has also included \$3,300,000,000 as a first-quarter advance for fiscal 1992, the same as the budget request.

PAYMENTS FOR AFDC WORK PROGRAMS

Appropriations, 1990	\$443,038,000
Budget estimate, 1991	1,000,000,000
House allowance	1,000,000,000
Committee recommendation	1,006,500,000

The Committee recommends \$1,006,500,000 for payments to States for AFDC work programs. This amount is \$6,500,000 more the level of the budget request and the House allowance.

This appropriation will support job opportunities and basic skills [JOBS] training programs in all States. Created by the Family Support Act of 1988, JOBS programs are intended to assure that needy families with children obtain the education, training, and employment they need to avoid long-term welfare dependence. States began to make the transition from existing AFDC and work incentives [WIN] programs to JOBS at the end of fiscal year 1989, and fiscal year 1991 is the first year in which JOBS programs must be operational in all States. As of the last quarter of fiscal year 1990, 35 States and territories have implemented this program.

The Committee has also included \$6,500,000 in its recommendation for additional job creation demonstrations authorized under section 505 of the Family Support Act of 1988. No funds were included in the budget request for these projects, although \$3,500,000 in funding is being awarded in fiscal year 1990 for 3-year grants to nonprofit organizations such as community development corporations. The House considered funding for this activity under the "Program administration" account, along with other demonstration projects, without identifying specific amounts for each. Funding the CDC demonstration under the JOBS authority would further formalize the link between the demonstration and the training program. It will also provide, potentially an avenue for the States to improve their placement of trainees. These grants provide technical and financial assistance to businesses that agree to target new job and enterprise opportunities to welfare recipients and welfare individuals at or below 100 percent of the poverty threshold. The Committee expects the job creation demonstration program to be administered by the Office of Community Services within the Family Support Administration.

The Committee recognizes the important Family Development and Self-Sufficiency Demonstration Grant [FaDSS] Program initiat-

ed in Iowa. This program represents the kind of approach that should be replicated across the United States to help troubled families achieve stability and self-sufficiency. The FaDSS Program is a coordinated effort of the FaDSS Council, the Iowa Department of Human Services, the Iowa Department of Human Rights/Division of Community Action Agencies, local community action agencies and other local providers. These partners work to provide services to troubled families under a framework which is flexible enough to respond to the unique needs of each family. The family development principles and funding of the State of Iowa are combined with the Federal Government's welfare reform principles and funding under the Jobs Opportunities and Basic Skills [JOBS] Program. The Committee encourages all States to look to the principles embodied in the FaDSS Program in fashioning programs which will stabilize family life and improve economic prospects.

LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM

Appropriations, 1990.....	\$1,443,000,000
Budget estimate, 1991.....	1,050,000,000
House allowance.....	
Committee recommendation.....	1,450,000,000

The Committee recommends an appropriation of \$1,450,000,000 for the Low-Income Home Energy Assistance Program [LIHEAP] in fiscal year 1991, a \$400,000,000 increase over the fiscal year 1991 President's budget and a \$7,000,000 increase over the fiscal year 1990 appropriation. The House deferred consideration due to lack of renewed authorizing legislation.

LIHEAP grants are awarded to the States, territories, and Indian tribes to assist low-income households in meeting the costs of home energy. Like all block grants, States are given great flexibility in the ways in which they provide assistance, including direct payments to individuals and vendors and direct provision of fuel. LIHEAP grants are distributed by a statutorily defined formula based in part on each State's share of home energy expenditures by low-income households nationwide.

The fiscal 1990 amount consisted of \$1,393,000,000 enacted in the regular Labor-HHS appropriation bill, and a \$50,000,000 supplemental for one-time emergency grants. Of the \$1,393,000,000 regular appropriation, \$60,000,000 was set aside through delayed obligations for use in starting up activities for this winter's program. Likewise, \$74,610,000 of the fiscal 1991 appropriation is reserved through delayed obligation for startup costs of next winter's LIHEAP program.

The program reports that States continue to transfer LIHEAP funds to other block grants. In fiscal year 1990, 29 States transferred an estimated \$53,000,000 to other programs. The Committee also notes that States have benefited from an infusion of oil overcharge funds over the past few years. Between 1986 and 1990, States received \$2,100,000,000 in Exxon overcharge funds, and \$1,300,000,000 in stripper well settlement funds. The Committee understands that States have designated \$591,000,000 of these funds for LIHEAP, and \$292,000,000 remains in undesignated funds

which could be used for meeting low-income home energy assistance needs.

ENERGY EMERGENCY CONTINGENCY FUND

Appropriations, 1990	
Budget estimate, 1991	
House allowance	
Committee recommendation	(1)

¹ Bill language providing \$200,000 contingency fund.

The Committee recommends bill language to establish an energy emergency contingency fund of \$200,000,000. The House did not consider this matter, for which there was no budget request.

Extraordinary circumstances in world oil markets pose a serious risk that low-income households will face skyrocketing home energy prices in the 1990-91 heating season. Low-Income Home Energy Assistance Program [LIHEAP] benefits in normal times cover less than one-quarter of recipients' home energy bills and are available to less than one-third of eligible households. Nearly 4 million low-income families heat with oil, kerosene, or liquid propane gas. In order to mitigate the effect of oil price increases in the 1990-91 heating season, the Committee action would create a contingency fund of \$200,000,000 in the U.S. Treasury to be available for grants under the Low-Income Home Energy Assistance Program after January 15, 1991, if the national average retail price of home heating oil exceeds by 20 percent or more the average of the national average retail price for home heating oil for the previous 4 years. According to the Congressional Budget Office, this bill language would not increase budget authority or outlays subject to the Committee's 302(b) allocation ceiling.

REFUGEE AND ENTRANT ASSISTANCE

Appropriations, 1990	\$374,862,000
Budget estimate, 1991	368,822,000
House allowance	
Committee recommendation	398,000,000

The Committee recommends \$398,000,000 for refugee and entrant assistance to assist an estimated 110,000 refugees expected to arrive in the United States in 1991. This represents an increase of \$29,178,000 over the President's budget. The House deferred consideration due to lack of renewed authorizing legislation.

The Refugee Assistance Program is designed to assist States in their efforts to assimilate refugees into American society as quickly and effectively as possible. The program reimburses States for State-administered cash and medical assistance, employment services, targeted assistance, preventive health, and the voluntary agency matching grant program.

The Committee believes that domestic refugee resettlement is critical in assimilating refugees into our society as soon as possible. To help meet this goal, the Committee allowance provides \$210,000,000 for cash and medical assistance, the same as the 1990 appropriation; \$85,000,000 for employment services, an increase of \$10,000,000 over the fiscal year 1990 appropriation; \$50,000,000 for targeted assistance, \$5,948,000 more than the fiscal year 1990 ap-

propriation; \$8,000,000 for preventive health; and \$45,000,000 for the voluntary agency program, an increase of \$5,000,000.

Within the amount for targeted assistance, the Committee expects that Dade County schools and Jackson Memorial Hospital will receive \$14,000,000 in special assistance, the same as fiscal year 1990.

The Committee recognizes the necessity of establishing funding priorities within the Cash and Medical Assistance Program. The Committee continues to believe that priority should be given to maintaining the 12-month reimbursement period for the RCA/RMA program. Because this is a partnership between the Federal Government, States and localities, the Committee expects the Department to consult regularly with State refugee coordinators in crafting or altering program funding priorities for fiscal year 1991.

The Committee is encouraged by the positive results of Fish-Wilson demonstration projects and urges the Secretary to maintain full support for these projects providing innovative alternatives to the traditional State administered resettlement programs. The Committee has been pleased by reports that the Department is exploring with certain States and localities options for additional Fish-Wilson projects. The Committee, however, is concerned over the recent withdrawal of support for the refugee early employment project administered by the State of Oregon. Not only does this threaten the viability of a successful demonstration project, it dampens the enthusiasm of other States for participation in alternative programs which provide comprehensive resettlement services. This is contrary to both the stated goals of the Department and the desire of the Committee.

The Committee is disturbed that the Department has ignored its direction, included in the Senate report accompanying H.R. 2990, to submit a report reviewing the findings of the Department's evaluation of the demonstration projects, the approval process, and recommendations for facilitating greater participation in alternative projects. The Committee again directs that such a report be provided no later than January 1, 1991.

The Committee continues to be concerned over the historic delays in funding announcements and the distribution of grant awards. Such delays make it extremely difficult for States and localities to properly plan and operate effective resettlement programs. The Committee directs the Department to implement appropriate measures to speed up the awarding of funds in fiscal year 1991 and apprise the Committee of the steps taken to implement this directive.

The Committee directs that not more than 5 percent of funding appropriated for social services be used for discretionary grants.

STATE LEGALIZATION IMPACT ASSISTANCE GRANTS

Appropriations, 1990	\$302,576,000
Budget estimate, 1991	302,597,000
House allowance	840,000,000
Committee recommendation	¹ 852,180,000

¹ Includes \$579,034,000 in fiscal year 1992 funding, which can be used for expenses incurred from fiscal year 1990 through 1994.

The Committee recommends an appropriation of \$852,180,000 for the State Legalization Impact Assistance Grants Program [SLIAG]. This is a net increase of \$12,180,000 from current appropriations, composed of a reduction of \$566,854,000 in the fiscal year 1991 amount, offset by an increase of \$579,034,000 in the fiscal year 1992 amount. The House did not alter funding for this program. The Committee action shifts funding to more closely reflect drawdown needs for this reimbursement program.

The administration's request for a rescission assumes that the original estimates for reimbursing States by the end of fiscal 1991 for the financial impact of legalization may be excessive. State expenditures are primarily for English language and history training, public health, and public assistance. Of the \$2,172,576,000 obligated to the States for fiscal years 1988, 1989, and 1990, States have drawn down \$862,400,000 as of August 1990. Through 1990, the Federal share has amounted to \$420,000,000. The Committee action provides an additional \$273,146,000 in fiscal 1991, and together with funds previously appropriated, raises fiscal 1992 funding to \$1,134,278,000. The Committee is committed to providing whatever Federal amount is necessary up to the \$4,000,000,000 previously appropriated, to reimburse States for costs approved under the law until the SLIAG Program expires in 1994. States and local service providers should, therefore, not diminish in any way activities to fully meet the needs of persons eligible for SLIAG services.

COMMUNITY SERVICES BLOCK GRANT

Appropriations, 1990	\$396,821,000
Budget estimate, 1991	33,959,000
House allowance	
Committee recommendation	448,300,000

The Committee recommends an appropriation of \$448,300,000 for the community services block grant, \$51,479,000 more than the fiscal year 1990 funding level.

The Community Services Block Grant [CSBG] Program makes formula grants to States and Indian tribes to provide a wide range of services and activities to ameliorate causes of poverty in communities and to assist low-income individuals become self-sufficient. The majority of CSBG funds go to community action agencies who administer these activities. A funding level of \$368,000,000 is recommended for the Community Services Block Grant Program.

The Committee believes that the community services programs have proved successful and vital in providing a wide array of services to the poor. Community action agencies, the mechanism by which most of these services are provided, largely depend on community services funds to maintain operations. These agencies provide valuable services to the poor in areas such as: employment, education, housing, nutrition, emergency services, and health. Thus, the Committee strongly urges the continuation of this program.

The Office of Community Services, which administers CSBG, also administers several discretionary programs, as well as the Demonstration Partnership Program, and the Community Food and Nutrition Program for which the following funding levels are recom-

mended in fiscal year 1991: National youth sports, \$11,100,000; community economic development, \$21,000,000; rural housing and community facilities, \$4,200,000; farmworker assistance, \$3,100,000; technical assistance, \$250,000; demonstration partnership, \$3,650,000; and community food and nutrition, \$2,500,000. Of the \$4,150,000 provided for the Demonstration Partnership Program, the Committee intends that approximately \$1,000,000 shall be for programs directed to special populations as specified in title VI of Conference Report 101-816. The Committee recognizes the need to find innovative solutions for solving the problems confronting disadvantaged youth, particularly among minority populations. The Committee is aware that a number of community action agencies in cities such as, Milwaukee, Boston, Fresno, Philadelphia, and Des Moines, are developing programs which respond to this critical need and encourages the Department to give careful consideration to their proposals when awarding grants.

Funds provided to community facilities technical assistance help rural communities gain clean drinking water and adequate waste disposal facilities. Small towns in many rural States have a great need for this assistance. For example, in Iowa 832 communities have populations of less than 2,500 people. Of these communities, nearly 30 percent do not have central sewer facilities. Increasing rural housing community facilities ensure that low-income rural communities receive the assistance they need to improve their drinking water and waste disposal facilities.

The Community Economic Development [CED] Program provides investment capital to nonprofit community development corporations [CDC's]. These funds are used, in conjunction with other public and private funds, to promote job creation and business opportunities in low-income urban and rural communities. The CED Program is important for rural America. Unemployment in rural areas is one-third higher than in urban areas and one-third more rural residents live in poverty than urban residents. Competition for CED funds is keen. For fiscal year 1990, the Office of Community Services received over 300 applications, four times the number that could be funded.

The Committee also recommends \$34,000,000, for the Community Services Homeless Program to total an appropriation of \$42,000,000, the same as the administration request (\$8,000,000 was forward funded for fiscal year 1991 in the fiscal year 1990 appropriations act). This is \$12,145,000 more than the 1990 funding level. These funds will allow for a comprehensive and coordinated effort to provide shelter to the homeless within each State.

PROGRAM ADMINISTRATION

Appropriations, 1990	\$85,453,000
Budget estimate, 1991	77,200,000
House allowance	80,200,000
Committee recommendation	83,200,000

The Committee recommends an appropriation of \$83,200,000 for program administration, which is \$6,000,000 over the level of the budget request and \$3,000,000 over the amount allowed by the House.

The "Program administration" account funds Federal administration costs for all Family Support Administration programs. These include: aid to families with dependent children, child support enforcement, JOBS, low-income home energy assistance, refugee and entrant assistance, and community services programs.

The recommendation for Federal administration includes \$500,000 over the request for an additional 10 FTE's, bringing total agency staffing to 1,039 FTE's. The increase is intended to strengthen monitoring of the JOBS Program, child support enforcement, and oversight of community service block grant and discretionary activities.

The Committee concurs with House bill language permitting currently authorized Federal parent locator service user fees to be retained in the FSA "Program administration" account, allowing the appropriation to be offset by \$1,000,000 in fiscal year 1991.

The Committee also agrees with House bill language extending the availability of fiscal year 1990 appropriations for the Commission on Child Support Enforcement through fiscal year 1991.

The FPLS assists States in locating absent parents who owe child support.

The Committee recommendation for research and evaluation is \$8,750,000, which is \$4,500,000 over the budget request, \$3,500,000 over the House allowance, but \$1,753,000 below the fiscal year 1990 appropriation. The Senate recommendation includes \$3,000,000 for child support visitation demonstrations, and \$1,500,000 for teen pregnancy demonstrations. Another \$6,500,000 for job creation demonstration activities is included under the "Payment to AFDC work programs" account. The House allowed \$2,000,000 for studies and demonstrations authorized in the Family Support Act.

The Committee recommendation includes \$3,000,000 for child support visitation demonstrations, as authorized by the Family Support Act of 1988. Under the provisions of the act, each project must be designed to improve the financial well-being of families with children.

The Committee recommendation includes \$3,000,000 for child access demonstration projects, as authorized in section 504 of the Family Support Act of 1988. Recognizing that the issue of access and visitation is of great concern to children and their noncustodial parents, the Committee urges the Family Support Administration to closely monitor the fiscal year 1990 grantees to reflect the intent of Congress to develop systematic procedures to enforce access provisions of court orders.

The Committee further directs the Family Support Administration to administer the fiscal year 1991 grants in such a manner so as to include a variety of agencies and organizations with a demonstrated history of expertise and performance in access enforcement, such as Fathers for Equal Rights, Des Moines, IA.

The Committee recommendation includes \$1,500,000 for teen care demonstration projects to provide counseling and services to high-risk teenagers, as authorized by the Family Support Act of 1988. These demonstration projects are intended to provide nonacademic programs and counseling to high-risk teenagers to reduce their rates of pregnancy, substance abuse, suicide, and school dropout.

Finally, the Committee recommendation includes bill language extending availability of prior year appropriations for the Commission on Interstate Child Support. The House has also included this language. The Commission, established under the authority of section 126 of the Family Support Act of 1988, is to make recommendations to the Congress on ways to improve the interstate establishment and enforcement of child support awards and on revisions to the Uniform Reciprocal Enforcement of Support Act [URESA].

ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

SOCIAL SERVICES BLOCK GRANT

Appropriations, 1990	\$2,762,200,000
Budget estimate, 1991	2,800,000,000
House allowance	2,800,000,000
Committee recommendation	2,800,000,000

The Committee recommends an appropriation of the full authorization level of \$2,800,000,000 for the social services block grant, the same as the administration request and the House allowance, and \$37,800,000 above the fiscal year 1990 postsequester level.

Social services block grant funds are used by States to fund a wide variety of social services for the purpose of preventing or reducing dependency, and assisting individuals achieve self-sufficiency. Activities include child and adult day care, child and adult abuse and neglect prevention, home-based services, and independent living services. States are entitled to their full share of the appropriated funds, and may use these funds to best suit the needs of the individuals residing within the State.

HUMAN DEVELOPMENT SERVICES

Appropriations, 1990	\$2,935,997,000
Budget estimate, 1991	3,327,502,000
House allowance	1,423,217,000
Committee recommendation	4,701,278,000

The Committee recommends an appropriation of \$4,701,278,000 for Human Development Services, \$1,373,776,000 more than the administration request and \$3,278,061,000 more than the House allowance.

The Human Development Services appropriation consists of programs for children, youth and families, the elderly, the developmentally disabled, and Native Americans, as well as Federal administrative costs.

The Committee expects the Assistant Secretary for Human Development Services to direct increased funds toward the implementation of a University of Hawaii education demonstration project which strengthens rural families with children from birth to 5 years of age and enhances the families' competence to nurture their children's health and development. The Committee further expects any activities funded to be coordinated with any University of Hawaii Center on the Family project which may be funded from increased funds made available to the Expanded Foods and Nutrition Education Program.

Head Start

Head Start provides comprehensive development services for low-income children and their families, emphasizing cognitive and language development, socioemotional development, physical and mental health, and parent involvement to enable each child to develop and function at his or her highest potential. At least 10 percent of enrollment opportunities in each State are made available to handicapped children.

The Committee recommends \$2,000,000,000 for the Head Start Program, \$113,685,000 more than the administration request and an increase of \$448,000,000 over the fiscal year 1990 appropriation level. The fiscal year 1991 increase will allow Head Start to serve up to an additional 160,000 children from low-income families over fiscal year 1990, for an estimated 668,420 low-income children in the program.

The administration request indicated that \$300,000 of Head Start funds would be used for travel for monitoring and technical assistance activities, especially those associated with implementing the program expansion in 1991. The Committee agrees with the need for making funds available specifically for Head Start monitoring and technical assistance, but believes the HDS Program Administration activity is the appropriate source for these Federal travel funds. Therefore, the Committee has added \$300,000 to HDS Program Administration specifically for Head Start monitoring and technical assistance activities.

The Committee is concerned about efforts by the Department to limit participation in the Head Start Program to 4-year-olds by giving priority to this group in awarding expansion funds. The Committee reiterates its position, stated in the past, that the ability of Head Start programs to offer more than 1 year of service to children and families is a key to its ability to adequately address the needs of an increasingly disadvantaged population. The Head Start Act explicitly states that local programs must have the option of providing more than 1 year of services, and the Committee believes this option must be preserved and adhered to by the Department. Therefore, the Committee directs the Department not to instruct grantees, or require them as a condition of receiving expansion funds, to in any way limit participation to 4-year-olds. Any attempt to limit Head Start moneys to 4-year-olds only is contrary to the act.

The Committee has included \$2,500,000 in the Head Start research, demonstration, and evaluation function to initiate a 3-year project to demonstrate the effectiveness of training Head Start teachers via interactive, education via satellite technology. The project shall be managed by a public television station with substantial experience in early childhood education teacher training and staff development programming in partnership with other public television stations, and the early childhood educational professional community. To the greatest extent possible, equipment and facilities provided previously by Federal funds shall be utilized.

The Committee notes that the Louis Meyer Children's Rehabilitation Institute of the University of Nebraska has developed a co-operative program with Head Start and other local educational and

social service agencies for an early childhood development program. The Committee recommends \$100,000 for this project.

The Committee also included \$1,431,000 for child development associate scholarships, the same level as the budget request and the fiscal year 1990 appropriation. These funds are used to assist low-income persons obtain certification as a child development associate in preparation for employment in a variety of child care and development agencies, including Head Start programs, day care, and other child care settings.

Comprehensive child development centers

This program is designed to encourage intensive, comprehensive, integrated, and continuous supportive services for low-income children from birth until they reach public school age. These services are intended to enhance the physical, emotional, and intellectual development of these children, and to provide support to their parents and other family members. The program targets infants and children from low-income families, who because of health, environmental, or other factors, need intensive and comprehensive support to enhance their growth and development.

The Committee recommends \$24,668,000, the same level as the administration request and the fiscal year 1990 appropriation. With these funds, the Secretary will make operating and planning grants to eligible public and nonprofit agencies, including Head Start agencies, community-based organizations, institutions of higher education, public hospitals, community development organizations, institutions of higher education, public hospitals, community development organizations, and organizations specializing in the delivery of services to infants or young children.

Child abuse and neglect/family violence

The Committee recommends \$51,500,000 for programs to improve and increase activities at all levels of government which identify, prevent, and treat child abuse and neglect through State grants, technical assistance, research, demonstration, and service improvement.

Included in this recommendation is \$20,000,000 for the child abuse State grants, \$15,000,000 child abuse discretionary activities, \$5,500,000 for the child abuse challenge grants, and \$11,000,000 for the Family Violence Prevention and Treatment Act.

Child abuse State grants have served as a catalyst to assist States to initiate 24-hour capability to respond to reports of child abuse and neglect; to support pilot projects for responding to child sexual abuse cases; and to establish parent aide and self-help programs. Grants will provide assistance to the States to improve and increase activities for the prevention, identification, and treatment of child abuse and neglect.

The Child Abuse Discretionary Program supports demonstration and service projects, and technical assistance projects to improve and increase national, State, community, and family activities for the prevention, identification, and treatment of child abuse and neglect through research, demonstration, service improvement, information dissemination, and technical assistance.

The Child Abuse Challenge Grants Program is designed to encourage States to create and maintain children's trust funds or other funding mechanisms using funds generated by State appropriations or other sources of State and local funding to support child abuse and neglect prevention activities.

The Family Violence Prevention and Treatment Act provides for formula grants to States and Indian tribes to assist in supporting programs and projects to prevent incidents of family violence and to provide immediate shelter and related assistance for victims of family violence and their dependents.

Runaway and homeless youth activities

For runaway and homeless youth programs, the Committee recommends \$46,500,000, an increase of \$7,848,000 over the budget request and the fiscal year 1990 funding level. These programs address the crisis needs of runaway and homeless youth and their families through support to local and State governments and private agencies.

This includes \$36,000,000 for the Runaway and Homeless Youth Act. In fiscal year 1990, an estimated 65,000 residential clients were served under this program. Testimony received in budget oversight hearings states that these shelters are often full, and youths seeking shelter are being turned away. Increased funding will help to expand needed facilities for this Nation's increasing population of runaway and homeless youth. This act requires that 90 percent of the funds go to community-based centers allocated to the State jurisdictions on the basis of the State youth population under 18 years of age in proportion to the national total. The remaining 10 percent networking and research and demonstration activities including the National Toll-Free Communications Center.

The Committee urges that the national communication system grant to assist runaway and homeless youth be awarded to an organization with a proven track record. This should include a successful and demonstrated outreach effort for both current and potential runaway and homeless youth. It should have nationwide recognition and should be easily recognizable by runaway and homeless youth, their parents, and families. Also, it should include a substantial volunteer base and significant private-donor base.

Also included is \$10,500,000 for the Runaway Youth Transitional Living Program. The Transitional Living Program was funded for the first time in fiscal year 1990. This program was created to fill a void and complement the services already provided in the temporary shelters under the Runaway and Homeless Youth Program. There is a growing population of homeless adolescents between the ages of 16 and 21 who are too old for foster care and too young for adult shelters, and consequently, have no place to go but the streets. Transitional living services will provide up to 540 days of shelter; promote self-sufficiency by helping adolescents access existing services, such as job training and education opportunities; and provide the support structure and other services needed to prepare homeless youth for productive independent lives.

Youth drug abuse prevention and education

The Committee recommends \$31,000,000 for activities related to youth drug abuse prevention and education, an increase of \$1,398,000 over the administration request and the fiscal year 1990 funding level.

This includes \$15,500,000 for drug education and prevention for runaway and homeless youth authorized by the Anti-Drug Abuse Act of 1988. This program makes grants to public and private non-profit organizations to support family and group counseling, community education, outreach, and drug abuse prevention training to individuals working with runaway and homeless youth. Also included is \$15,500,000 for the Drug Education and Prevention Program for youth gangs, also authorized by the Anti-Drug Abuse Act of 1988. The purpose of this program is to reduce and prevent the participation of youth gang's in illicit drug activities.

Child care

The Committee recommends \$1,200,000,000 to carry out provisions under title I of S. 5, the Senate-passed act for better child care. This includes \$1,140,000,000 for State grants and \$60,000,000 for liability risk retention grants. The House did not consider this funding and there is no budget request.

The Senate-passed substantive legislation authorized up to \$1,750,000,000 for child care State grants, and up to \$100,000,000 for liability risk retention grants. The Committee allowance is for startup costs, to be made available for obligation on September 15, 1991. This should provide adequate lead time for planning and promulgation of any necessary regulations, and for States to gear up for effective implementation. The administration is expected to submit a budget request to cover program direction expenses.

The funds recommended for liability risk retention grants are intended to increase the availability of child care by alleviating the serious difficulty faced by child care providers in obtaining affordable liability insurance, and to provide States with a sufficient capital base for liability insurance purposes that may be increased or maintained through mechanisms developed by the State.

Of the funds recommended for State grants, at least 70 percent is for direct child care expenses with the remainder available for such activities as resource and referral services, activities aimed at increasing availability of child care services, training, and technical assistance.

Dependent care planning and development

The Dependent Care Program provides grants to States for activities related to dependent care resource and referral systems and school-age child care services. These funds are to be used to assist in the planning, development, establishment, and expansion or improvement of child care services, but are not to be used for operating costs associated with specific referral or child care services.

The Committee recommends \$13,500,000 for dependent care programs, an increase of \$322,000 over fiscal year 1990 funding levels and the budget request.

Child welfare services

The Committee recommends total funding of \$300,000,000 for child welfare services, \$47,352,000 of which is to be transferred from the Foster Care Program. This represents an increase of \$47,352,000 over the fiscal year 1990 funding level.

This program helps State public welfare agencies improve their child welfare services with the goal of keeping families together. State services include: preventive intervention, so that, if possible, children will not have to be removed from their homes; development of alternative placements like foster care or adoption if children cannot remain at home; and reunification so that children can return home if at all possible. All States are eligible to receive a share of the first \$141,000,000 appropriated for child welfare services, and as an incentive to States. Only those States implementing the specific protections for children outlined in title IV of the Social Security Act, are eligible to receive a share of the appropriation in excess of \$141,000,000.

Child welfare training

The Committee recommends \$3,647,000 for child welfare training, the same level as the budget request and the fiscal year 1990 enacted level.

This program provides grants to public and private institutions of higher learning to develop and improve education/training programs for child welfare service providers.

Child welfare research and demonstrations

The Committee recommends an appropriation of \$8,000,000, an increase of \$483,000 over the fiscal year 1990 funding level. The child welfare research and demonstration funds support research and demonstration activities in four basic areas: child welfare, child care, youth development, and family and child development, with the basic goal of strengthening the family as the primary agent responsible for the developmental needs of children and youth.

Congress examined, last year, a series of incidents involving child abuse and sexual molestation of approximately 144 children by a BIA teacher on the Hopi Indian Reservation. In response to the tragedy, the Hopi Tribe established a counseling and treatment program to provide assistance to the victims and their families. The Committee directs that within the amount provided, \$150,000 be allocated to the Hopi child sexual abuse project to support child abuse education and prevention efforts.

The Committee does not concur with the administration's request for an additional \$6,000,000 for another crack babies demonstration initiative, but rather has increased by \$6,000,000 the two existing programs (abandoned infants assistance and temporary child care and crisis nurseries) already administered by HDS that address the immediate, nonmedical needs of infants born to crack- and cocaine-using mothers and HIV-infected children.

The Committee is concerned over recent reports regarding the increase in the use of illegal drugs by pregnant women. Some estimates indicate that 375,000 infants are born drug exposed or HIV

infected each year. These infants are more likely to be born premature, resulting in low-birth weight, suffer withdrawal symptoms, and for the drug-exposed children, experience developmental and behavioral problems.

Temporary child care and crisis nurseries

The Committee recommends \$11,328,000 for the Temporary Child Care and Crisis Nurseries Program, an increase of \$3,000,000 over the administration request and the 1990 funding level. Grants are made to States which apply to support demonstration projects by local governments and private nonprofit agencies. This program is intended to demonstrate the effectiveness of assisting States to provide temporary, nonmedical care for children with special needs and children that are abused and neglected or at risk of abuse and neglect.

Abandoned infants

The Committee recommends \$12,867,000 for the Abandoned Infants Assistance Program, an increase of \$3,000,000 over fiscal year 1990 funding level and the administration request. This program was funded for the first time in fiscal year 1990 and provides support for discretionary grants to develop and demonstrate prevention and intervention strategies to prevent the abandonment of infants—especially those infected with HIV—and to provide necessary and appropriate care for those infants that are abandoned. This program also supports special studies and technical assistance to assure the availability of effective service models and intervention strategies.

Adoption opportunities

The Committee recommends \$13,000,000 for adoption opportunities, \$6,264,000 more than the budget request and the fiscal year 1990 appropriation.

This program eliminates barriers to adoption and helps find permanent homes for children who would benefit by adoption, particularly children with special needs. This funding level includes \$4,000,000 for postlegal adoption services (an increase of \$3,000,000 over fiscal year 1990) and \$4,000,000 for minority children placement (an increase of \$3,200,000 over fiscal year 1990). This program also funds the National Adoption Clearinghouse, a national adoption information exchange system.

Aging

The Committee recommends an appropriation of \$787,000,000 for aging programs, an increase of \$64,836,000 over the budget request and \$64,837,000 above the fiscal year 1990 appropriations.

Supportive services and senior centers

This State Formula Grant Program funds a wide range of social services for the elderly, including multipurpose senior centers and ombudsman activities. State agencies on aging make awards to area agencies on aging on the basis of State-approved area plans and intrastate funding formulas.

The Committee recommends an appropriation of \$298,000,000 for supportive services and senior centers, an increase of \$26,013,000 over fiscal year 1990 and \$25,039,000 over the budget request.

Congregate and home-delivered nutrition services

The Committee recommends an appropriation of \$460,000,000 for total nutrition services, including \$370,000,000 for congregate meals, and \$90,000,000 for home-delivered meals.

This program provides funds for operating and establishing nutrition services projects for the elderly. Projects funded must make home-delivered and congregate meals available at least once a day, 5 days a week, and each meal must meet one-third of the minimum daily dietary requirements.

Grants to Indian tribes

The Committee recommends a total of \$16,000,000 for title VI grants to Indian tribes and Native Hawaiians, the same level as the fiscal year 1990 funding level. In accordance with the distribution of funds mandated by the Older Americans Act, of the amount provided, \$14,495,000 will fund part A, grants to Indian tribes, and \$1,505,000 will fund part B, grants to Native Hawaiians.

This program promotes the delivery of supportive services, including nutrition services to American Indians, Alaskan Natives, and Native Hawaiians. Part A grants are made to Indian tribes with at least 50 older Indians who are 60 years of age or older, and part B grants are made to public or nonprofit private organizations serving at least 50 older Native Hawaiians who are 60 years of age or older.

The number of eligible grantees applying for title VI-A grants has risen dramatically in recent years, from approximately 130 in fiscal year 1988 to over 190 expected in 1990. Because the Commissioner on Aging is required to fund all eligible tribes that apply for funds under title VI, the Committee provided significantly increased funding levels in 1989 and 1990. It is expected that the number of eligible grantees applying for funds in fiscal year 1991 could reach as high as 210.

Ombudsman/elder abuse

The Committee recommends a total of \$6,000,000 for the ombudsman and elder abuse programs.

The Committee recommends \$3,000,000 to continue and expand support for the long-term care ombudsman activities, an increase of \$2,027,000 over the budget request and the fiscal year 1990 funding level. The authority and responsibilities of the long-term care ombudsman program, which provides critical assistance to nursing home and board and care residents, were significantly expanded by the Older Americans Act Amendments of 1987. The additional funding provided should enable these programs to extend their presence in long-term care facilities by increasing the number of full- and part-time State and trained volunteers. The Committee is concerned with the level of staffing support within the Administration on Aging for this program, and urges the Administration to enhance its ability to provide technical support and assistance to the many State and local long-term care ombudsman programs.

The Committee is aware of the alarming increases in the incidence of abuse, neglect, and exploitation of older Americans. A recent congressional study found that the number of elderly victims of abuse has increased from 1 to 1.5 million over the last decade. Therefore, the Committee has provided \$3,000,000 in initial funding for the Elder Abuse Prevention Program authorized by section 371 of the Older Americans Act. It is expected that these funds will allow States to initiate or expand efforts to improve public awareness of the problem of elder abuse, neglect and exploitation, its causes, and sources of assistance for victims.

In-home services for frail elderly

The Committee recommends \$7,000,000 for in-home services for the frail elderly, an increase of \$1,244,000 over the administration request and the fiscal year 1990 appropriation. In-home services include homemaker and home health aides, visiting and telephone reassurance, chore maintenance, in-home respite care for families, and minor home modifications.

Aging research and training

The Committee recommends \$27,332,000 for aging research, training, and discretionary programs, \$2,000,000 above the fiscal year 1990 appropriation.

The Committee intends \$1,000,000 of the increase be used to fund the 1991 White House Conference on Aging as authorized by the Older Americans Act Amendments of 1987. The Committee believes that this conference holds great promise in developing mechanisms and plans to meet the needs of our increasing older population in the years to come by bringing together national and local leaders, experts, and activists in older persons' programs. The Committee also urges that the 1991 conference discuss and make recommendations on ways to further enhance intergenerational activities and programs. The number of intergenerational programs has increased in recent years and most have been highly successful and beneficial to both the younger and older participants.

The Aging Research, Training, and Demonstrations Program supports activities in gerontological career preparation, in-service training, and knowledge transfer and utilization. The program also supports 11 national aging resource centers and an Executive Leadership Institute on Aging. The national resource centers provide assistance to State and area agencies on aging in such areas as long-term care, minority aging, health promotion, ombudsman, and elder abuse. Other projects supported are legal services activities and research projects in the areas of improving community systems for responding to the needs of the elderly and the nature and causes of alcoholism among the elderly.

The Committee has also included \$1,000,000 for projects to demonstrate innovative ways of providing support to victims of Alzheimer's disease and their families. The Committee recognizes the tremendous physical, financial, and emotional straining experienced by families caring for a spouse or parent suffering from Alzheimer's, and realizes these burdens can be alleviated to a certain extent when appropriate support services are available in the community. Specifically, the Committee expects AOA to fund demon-

stration projects that will improve the availability and affordability of quality respite care, and other supportive services, for Alzheimer's victims and their families, thereby making it easier for families to care for members with Alzheimer's at home.

Increases in funding will enable the Administration on Aging to implement its eight articulated goals for 1990, including the provision of adequately trained personnel in the field of aging, improving knowledge on the problems and needs of older Americans, and demonstrating new methods of improving the quality of life of elderly persons.

The Committee directs the administration to increase funding for education, training, and research activities under title IV. Priority activities should include career preparation training, as well as student stipends and faculty development grants.

The Committee encourages the AOA to increase funding for education and training activities to emphasize the need for qualified personnel trained and educated in the field of aging. The Committee is impressed with the high percentage of individuals assisted by title IV career preparation training who have remained in the field of aging. The Committee recommends that the Administration on Aging use a portion of the funding for education and training activities to recruit more minorities into the field of aging.

The Committee directs AOA to continue its ongoing assessment of short-term and long-range personnel needs in the field of aging. The AOA should fund specific projects to implement this objective.

The Committee believes that AOA-sponsored research and training should emphasize a focus on the behavioral and social aspects of aging, since the NIA, the NIMH, and the Bureau of Health Professions are all authorized to fund health-related programs.

The Committee directs AOA to increase funding for national minority organizations with a proven track record in providing representation and services to aged minorities. The Committee commends the AOA for its recent efforts to promote minority participation in the Older Americans Act programs.

The Committee reaffirms its support of the long-term care gerontology centers and urges that they be continued and fully funded.

The Committee also directs AOA to continue to fund legal services support and demonstration projects at a minimum of \$1,500,000. National legal services support and demonstration projects mean those which are (1) conducted by national nonprofit legal assistance organizations which provide support and demonstrations on a national basis to local legal assistance providers; and (2) provide national assistance support and demonstrations to local legal assistance providers or State and area agencies on aging for the purpose of providing, developing, or supporting legal assistance for older individuals, including case consultations; training; and provision of substantive legal advice and assistance in the design, implementation, and administration of free legal assistance delivery systems.

Developmental disabilities

The Committee recommends \$104,100,000 for developmental disabilities programs, an increase of \$5,623,000 over the administration request and the fiscal year 1990 appropriation.

The Administration on Developmental Disabilities supports community-based delivery of services which promote the rights of persons of all ages with developmental disabilities. Developmental disability is defined as a severe, chronic disability attributed to mental or physical impairments manifested before age 22, which causes substantial limitations in major life activities.

The Committee is aware of the need to increase education, training, and technical assistance to aid potential employers in accommodating the workplace needs of persons with disabilities. The Committee urges the Administration on Developmental Disabilities to explore innovative strategies to provide such assistance.

Basic State grants

For State grants, the Committee recommends \$66,000,000, an increase of \$4,061,000 over the budget request and fiscal year 1990 funding level. This program provides grants to States to plan and conduct activities that increase the capacities and resources of agencies to develop, coordinate, or stimulate permanent improvement in systems of services for persons with developmental disabilities, with priority given to those persons whose needs are not otherwise met under other health, education, and human service programs.

Protection and advocacy grants

For protection and advocacy grants, the Committee recommends \$21,500,000, an increase of \$1,016,000 over the budget request and the fiscal year 1990 appropriation.

This formula grant program provides funds to States to establish protection and advocacy systems to protect the legal and human rights of persons with developmental disabilities who are receiving treatment, services, or rehabilitation within the State.

Projects of national significance

The Committee recommends \$3,100,000, an increase of \$238,000 over the fiscal year 1990 funding level and the administration request.

This program funds grants and contracts providing nationwide impact by developing new technologies and applying and demonstrating innovative methods to support the independence, productivity, and integration into the community of persons with developmental disabilities.

In 1990, over 14,000 persons with developmental disabilities were surveyed on their level of satisfaction with the health, educational, vocational, and residential services they receive at the State and local level. Data emanating from those interviews will be a valuable source of information for future Federal and State policymaking. Therefore, the Committee encourages the Secretary to consider the continuation of work on the national consumer survey, which is administered through projects of national significance.

University-affiliated programs

This program provides operational and administrative support for a national network of university-affiliated programs and satellite centers. Grants are made annually to university-affiliated pro-

grams and satellite centers for interdisciplinary training, exemplary services, technical assistance, and information dissemination activities.

The Committee recommends \$14,250,000 for this program, an increase of \$1,058,000 over the fiscal year 1990 funding level and the fiscal year 1991 budget request. The Committee expects that \$750,000 will be used for training grants and the remaining \$308,000 of the increase in funding will be used to provide cost-of-living adjustments to existing UAP's.

Native American programs

The Administration on Native Americans administers direct financial assistance grants, contracts, and interagency agreements to federally recognized and nonfederally recognized tribes and Native American organizations to promote social and economic self-sufficiency.

The Committee recommends \$34,200,000 for this program, an increase of \$2,489,000 over the budget request and the fiscal year 1990 appropriation. The Committee has included \$1,000,000 to implement the planning process for the establishment of a national center for Native American studies and policy development at George Washington University, as authorized under Public Law 101-301.

Social services research

The Committee recommends \$3,975,000, an increase of \$500,000 over the administration request and the fiscal year 1990 funding level. This program supports activities authorized by section 1110 of the Social Security Act, and are used to support cross-cutting research, demonstration evaluation, and dissemination activities with the goal of reducing dependency and increasing self-sufficiency among the most vulnerable populations. Projects supported include collaboration between health and social service delivery systems for children with pediatric aids, and training family caregivers, and planning for the life-long services needs of individuals with disabilities and the elderly.

The Committee has provided \$500,000 to carry out demonstration projects to determine whether the use of volunteer senior aids to provide medical assistance and support to families with disabled or chronically ill children contributes to reducing the costs of care for such children as authorized under section 10404 of the 1989 Reconciliation Act.

Program direction

This activity supports Federal staff that administer all of the programs in the Office of Human Development Services. The Committee recommends \$73,000,000 for this activity, \$1,851,000 above the budget request and \$4,687,000 over the fiscal year 1990 funding level. The Committee expects that \$300,000 of the increase will be used to fund monitoring and technical assistance activities for the Head Start Program, especially those activities associated with implementing the program expansion in 1991. The Committee has also included \$1,200,000 to establish a national center to disseminate

nate information about family resource programs, provide training and technical assistance, and to evaluate family resource programs.

PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE

Appropriations, 1990	\$1,374,916,000
Budget estimate, 1991	2,471,283,000
House allowance	2,632,192,000
Committee recommendation	2,611,281,000

The Committee recommends an appropriation of \$2,611,281,000 for payments to States for foster care and adoption assistance. The recommended amount reflects the mid-year estimate by the Department of Health and Human Services on funding required for the Foster Care and Adoption Assistance Program. Of the total recommended appropriation, \$1,793,186,000 would be for fiscal year 1991 foster care claims, \$47,352,000 is for child welfare services, \$520,911,000 would fund foster care shortfalls in full for fiscal years 1989 and 1990, \$172,704,000 would be for adoption assistance, \$17,218,000 would be for prior-year claims under the Adoption Assistance Program, and \$60,000,000 would fund the Independent Living Program.

The Foster Care Program provides Federal reimbursement to States for: maintenance payments to families and institutions caring for eligible foster children, matched at the Medicaid medical assistance rate for each State; and administration and training costs to pay for the efficient administration of the foster care program, and for the training of foster care workers and parents.

The Adoption Assistance Program provides funds to States to assist in paying maintenance costs, and the nonrecurring costs of adoption, for children with special needs, with the goal of facilitating the placement of hard to place children in permanent adoptive homes, and thus prevent long, inappropriate stays in foster care. As in the Foster Care Program, State administrative and training costs are reimbursed under this program.

DEPARTMENTAL MANAGEMENT

GENERAL DEPARTMENTAL MANAGEMENT

Appropriations, 1990	\$79,416,000
Budget estimate, 1991	81,350,000
House allowance	82,250,000
Committee recommendation	75,500,000

The Committee recommends an appropriation of \$75,500,000 for general departmental management. This is \$5,850,000 less than the administration request, \$6,750,000 below the House allowance, and \$3,916,000 less than the fiscal year 1990 level.

The Committee also recommends the transfer of \$28,950,000 from the Social Security and Medicare trust funds, \$2,150,000 below the administration's request and the fiscal year 1990 amount, and \$3,000,000 less than the House amount.

The general departmental management appropriation supports activities associated with the Secretary's roles as policy officer and general departmental manager, including the areas of public af-

fairs, executive secretariat, legislative services, planning and evaluation, procurement assistance, facilities management, legal services, and policy planning and functional guidance for all departmental operations.

In fiscal year 1990, it was brought to the Committee's attention that HHS spends up to \$1,000,000,000 on transportation services for the elderly, those with disabilities, children, and the poor; yet organizations operating transportation systems in rural areas are often unable to receive technical assistance from Federal transportation agencies or coordinate effectively with other transportation programs. Through an interagency agreement between HHS and the Department of Transportation Urban Mass Transportation Administration [UMTA], grant funds are being made available to provide needed information, technical assistance and training to HHS recipients to improve the efficient use of existing transit resources, equipment, and facilities. In addition, a report to the Secretary is being prepared which will list the needed improvements in law, regulation, and procedure to improve efficiency.

While the report is not yet complete, several techniques for reducing costs and improving the efficiency of human service transportation have been identified:

In Dade County, FL, over \$250,000 was saved in the medical assistance program in 1 year by utilizing a coordinated provider of transit services to Medicaid recipients.

In Pennsylvania, the average cost per medical trip was reduced by more than 50 percent following the introduction of a coordinated system of human service transportation, which provides over 4 million medical assistance trips annually.

In Nassau County, FL, the average per-trip cost of nonemergency medical transportation was reduced from \$100 to \$25 as a result of establishing a coordinated system of human service transportation and promoting competitive bidding among available providers.

The Committee concurs with the House Committee in directing the continuation of the technical assistance program in fiscal year 1990 with an additional \$250,000 from the "Departmental management" account.

The Committee looks forward to the completion of the report so that improvements may be made in human services transportation systems.

In addition, the Committee notes that the enactment of the Americans with Disabilities Act [ADA] will significantly increase the demand for paratransit services to persons with disabilities. Titles II and III of the act may place significant new requirements on rural and human service agencies providing transit services and also opportunities to participate in local planning aimed at establishing supplemental paratransit services in each community.

The Committee has, therefore, included an additional \$250,000 in grant funds to carry out a program of targeted assistance to State human service agencies and rural and local HHS recipients providing transportation to individuals with disabilities. The purpose of this ADA initiative is to increase awareness among HHS recipients of their obligations under the ADA and to ensure that existing HHS-funded transportation efforts directed toward the special needs of disabled persons are maintained at current levels and op-

erated in a coordinated manner with other public transit services available in the community.

The targeted assistance will include conducting a series of regional training programs for rural and human service transportation providers and State officials covering all aspects of Federal accessibility requirement, including legal and other obligations under the ADA for the provision of accessible transportation and para-transit services.

Such a program of assistance is to be carried out by a qualified national organization with a record of assisting rural and special transportation needs.

The Committee is impressed with recent National Research Council conclusions that surveys continue to be one of the most important techniques to obtain information relevant to HIV and AIDS, and that the vast majority of the American public will cooperate with surveys of sexual and drug use behavior. The Committee is dismayed that the survey of health and AIDS risk prevalence [SHARP] continues to be delayed, and urges the Department to approve the feasibility phase of SHARP promptly. Upon completion of the pilot study by the NICHD, the Committee requests that the Institute recommend whether to launch the full-scale phase of the study and, if appropriate, to make a specific request for this.

It has come to the Committee's attention that the Department has undertaken efforts to consolidate the functions performed by the Division of Cost Allocation. The Committee believes region-based negotiators have saved the Federal Government millions of dollars in indirect cost expenses annually, and notes earlier departmental analysis that any increase in the DCA yields a high return in real dollar savings to the Federal Government. The Committee, therefore, directs the Department to continue operation of the DCA with its present regional office structure and with the Federal staff necessary to perform its functions.

OFFICE OF THE INSPECTOR GENERAL

Appropriations, 1990	\$50,488,000
Budget estimate, 1991	51,500,000
House allowance	53,500,000
Committee recommendation	53,500,000

The Committee recommends new budget authority of \$53,500,000 for the Office of the Inspector General [OIG], plus a \$43,723,000 transfer from the Social Security trust funds for total obligational authority of \$97,223,000. This amount is \$2,000,000 above the administration's request, the same as the House amount, and \$3,012,000 more than the fiscal year 1990 appropriation.

The Office of the Inspector General conducts audits, investigations, and inspections and evaluations of the six operating divisions within the Department of Health and Human Services. The OIG functions with the goal of reducing the incidence of fraud, waste, abuse, and mismanagement, and promoting economy, efficiency, and effectiveness throughout the Department.

OFFICE FOR CIVIL RIGHTS

Appropriations, 1990	\$17,294,000
Budget estimate, 1991	17,585,000
House allowance	17,585,000
Committee recommendation.....	17,585,000

The Committee recommends \$17,585,000 in Federal funds for the Office for Civil Rights [OCR], which is an increase of \$291,000 from the fiscal year 1990 amount and the same as the House allowance and the administration's request. Also included is authority to spend \$4,000,000 from the Social Security trust funds, the same as the fiscal year 1990 amount.

OCR is responsible for enforcing civil rights-related statutes in health care and human services programs. To enforce these antidiscrimination statutes, the Office investigates complaints of discrimination, conducts comprehensive reviews of programs to correct discriminatory practices, conducts outreach initiatives, and provides technical assistance to encourage voluntary compliance among health and human services providers and constituency groups.

POLICY RESEARCH

Appropriations, 1990	\$5,001,000
Budget estimate, 1991	5,017,000
House allowance	9,167,000
Committee recommendation.....	8,167,000

The Committee recommends an appropriation of \$8,167,000 for policy research. This is \$3,150,000 above the administration request, \$1,000,000 below the House allowance, and \$3,166,000 more than the fiscal year 1990 appropriation.

The policy research program, authorized by section 1110 of the Social Security Act, constitutes one of the Department's principal sources of policy-relevant data and research on income sources of the low-income population; on the impact, effectiveness, and distribution of benefits under existing or proposed programs; and, on specific issues that impact upon programs affecting more than one agency within the Department. Policy research is used to analyze issues that cannot be covered in other departmental research programs or under existing evaluation activity.

The Committee has provided funding to continue the ongoing, highest priority research and further development of simulation models used for analysis of policy alternatives. In addition, the Committee has added \$3,150,000 for poverty research initiatives.

\$38,014,000 for ADAMHA research training programs;
 \$9,431,000 for adolescent family life;
 \$1,450,000,000 for LIHEAP;
 \$398,000,000 for refugee and entrant assistance
 \$448,300,000 for community services block grant;
 \$2,000,000,000 for Head Start;
 \$1,431,000 for child development associate scholarships;
 \$13,500,000 for dependent care planning and development;
 \$104,100,000 for developmental disabilities programs;
 \$7,465,000 for Follow Through;
 \$196,878,000 for education for the handicapped;
 \$985,165,000 for vocational and adult education;
 \$53,083,000 for the Soldiers' and Airmen's Home.

COMPLIANCE WITH PARAGRAPH 12, RULE XXVI OF THE STANDING RULES OF THE SENATE

Paragraph 12 of rule XXVI requires that Committee reports on a bill or joint resolution repealing or amending any statute or part of any statute include "(a) the text of the statute or part thereof which is proposed to be repealed; and (b) a comparative print of that part of the bill or joint resolution making the amendment and of the statute or part thereof proposed to be amended, showing by stricken-through type and italics, parallel columns, or other appropriate typographical devices the omissions and insertions which would be made by the bill or joint resolution if enacted in the form recommended by the committee."

No items are identified pursuant to this requirement.

DEFINITION OF PROGRAM, PROJECT, AND ACTIVITY

During fiscal year 1991 for purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177), as amended, the following information provides the definition of the term "program, project, and activity" for departments and agencies under the jurisdiction of the Labor, Health and Human Services, and Education and Related Agencies Subcommittee. The term "program, project, and activity" shall include the most specific level of budget items identified in the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act 1990, the accompanying House and Senate Committee reports, the conference report and accompanying joint explanatory statement of the managers of the committee of conference and the tables inserted in the Congressional Record on the days when the bill or conference report is considered in the House.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

TITLE I -- DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

PROGRAM ADMINISTRATION

	FY 1990 Comparable	FY 1991 Budget Request	House Bill Recommendation	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House Bill
Job training programs.....	18,540,000	19,834,000	19,834,000	19,834,000	+1,294,000	---	---
Trust funds.....	(2,057,000)	(2,170,000)	(2,170,000)	(2,170,000)	(+113,000)	---	---
Employment security.....	442,000	464,000	464,000	464,000	+22,000	---	---
Trust funds.....	(13,032,000)	(13,406,000)	(13,406,000)	(13,406,000)	(+374,000)	---	---
Financial and administrative management.....	14,055,000	14,330,000	14,880,000	14,330,000	+274,000	---	-550,000
Trust funds.....	(10,544,000)	(10,586,000)	(11,036,000)	(10,586,000)	(+42,000)	---	(-450,000)
Executive direction and administration.....	3,806,000	4,283,000	4,283,000	4,283,000	+477,000	---	---
Trust funds.....	(3,097,000)	(3,360,000)	(3,360,000)	(3,360,000)	(+263,000)	---	---
Regional operations.....	12,268,000	12,962,000	15,962,000	15,962,000	+3,694,000	+3,000,000	---
Trust funds.....	(24,384,000)	(24,779,000)	(24,779,000)	(24,779,000)	(+395,000)	---	---
Apprenticeship services.....	15,517,000	14,607,000	14,607,000	16,607,000	+1,090,000	+2,000,000	+2,000,000
Total, Program Administration.....	117,743,000	120,781,000	124,781,000	125,781,000	+8,038,000	+5,000,000	+1,000,000
Federal funds.....	64,629,000	66,480,000	70,030,000	71,480,000	+6,851,000	+5,000,000	+1,450,000
Trust funds.....	(53,114,000)	(54,301,000)	(54,751,000)	(54,301,000)	(+1,187,000)	---	(-450,000)

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	Budget Request	House Bill	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House Bill
TRAINING AND EMPLOYMENT SERVICES 1/							
Grants to States:							
Block grant.....	1,744,808,000	1,744,808,000	1,900,000,000	1,744,808,000	---	---	-155,192,000
Summer youth employment and training program.....	699,777,000	699,777,000	699,777,000	699,777,000	---	---	---
Dislocated worker assistance 2/.....	463,603,000	400,000,000	513,603,000	550,000,000	+86,397,000	+150,000,000	+36,397,000
Federally administered programs:							
Native Americans.....	58,193,000	57,579,000	58,193,000	64,000,000	+5,807,000	+6,421,000	+5,807,000
Migrants and seasonal farmworkers.....	69,047,000	55,834,000	69,047,000	75,000,000	+5,953,000	+19,166,000	+5,953,000
Job Corps:							
Operations.....	752,868,000	781,281,000	837,000,000	807,500,000	+54,632,000	+26,219,000	-29,500,000
Construction and renovation 3/.....	49,746,000	36,103,000	63,740,000	74,100,000	+24,354,000	+37,997,000	+10,360,000
Subtotal, Job Corps.....	802,614,000	817,384,000	900,740,000	881,600,000	+78,986,000	+64,216,000	-19,140,000
Veterans' employment.....	9,345,000	8,863,000	9,345,000	9,345,000	---	+482,000	---
National activities:							
Pilots and demonstrations.....	30,467,000	27,753,000	28,753,000	45,467,000	+15,000,000	+17,714,000	+16,714,000
Research, demonstration and evaluation.....	15,712,000	13,246,000	13,246,000	13,246,000	-2,466,000	---	---
Other.....	24,045,000	13,983,000	17,983,000	26,045,000	+2,000,000	+12,062,000	+8,062,000
Subtotal, National activities.....	70,224,000	54,982,000	59,982,000	84,758,000	+14,534,000	+29,776,000	+24,776,000
Subtotal, Federal activities.....	1,009,423,000	994,642,000	1,097,307,000	1,114,703,000	+105,280,000	+120,061,000	+17,396,000
Total, Job Training Partnership Act.....	3,917,611,000	3,839,227,000	4,210,687,000	4,109,288,000	+191,677,000	+270,061,000	-101,399,000

1/ Excludes \$317,141,000 in legislative additions proposed for later transmittal.

2/ The Administration proposed funding this activity in a separate account, "Worker readjustment assistance".

3/ Reflects budget amendment proposed by the President 4/24/90 that would reduce the original request by \$637,000.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House Bill DEFER	Senate Recommendation	FY 1990	Senate Compared with FY 1991 Budget	House Bill
Job training for the homeless.....	(11,343,000)	(11,500,000)	---	(11,500,000)	(+157,000)	---	(+11,500,000)
Advance funding for FY 1991.....	1,500,000	---	---	---	-1,500,000	---	---
Total, Training and Employment Services.....	3,919,111,000	3,839,227,000	4,210,687,000	4,109,288,000	+190,177,000	+270,061,000	-101,399,000
Current year, FY 1990.....	(3,917,611,000)	(3,839,227,000)	(4,210,687,000)	(4,109,288,000)	(+191,677,000)	(+270,061,000)	(-101,399,000)
Advance funding for FY 1991.....	(1,500,000)	---	---	---	(-1,500,000)	---	---
Unauthorized, not considered by House.....	(11,343,000)	(11,500,000)	DEFER	(11,500,000)	(+157,000)	---	(+11,500,000)
Total, authorized and unauthorized.....	(3,930,454,000)	(3,850,727,000)	(4,210,687,000)	(4,120,788,000)	(+190,334,000)	(+270,061,000)	(-89,899,000)

COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

National contracts.....	286,270,000	267,395,000	312,000,000	312,000,000	+25,730,000	+44,605,000	---
State grants.....	80,743,000	75,419,000	88,000,000	88,000,000	+7,257,000	+12,581,000	---
Total.....	367,013,000	342,814,000	400,000,000	400,000,000	+32,987,000	+57,186,000	---

FEDERAL UNEMPLOYMENT BENEFITS AND ALLOWANCES 1/

Trade adjustment.....	280,024,000	230,000,000	230,000,000	269,000,000	-11,024,000	+39,000,000	+39,000,000
Other activities.....	---	500,000	500,000	500,000	+500,000	---	---
Total.....	280,024,000	230,500,000	230,500,000	269,500,000	-10,524,000	+39,000,000	+39,000,000

1/ Excludes \$230,500,000 in legislative savings proposed for later transmittal.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House 8111 Recommendation	Senate Recommendation	Senate compared with FY 1991 Budget	
					FY 1990	House 8111
STATE UNEMPLOYMENT INSURANCE AND EMPLOYMENT SERVICE OPERATIONS						
Unemployment Compensation (Trust Funds):						
State operations 1/.....	(1,257,673,000)	(1,357,695,000)	(1,403,751,000)	(1,403,751,000)	(+146,078,000)	(+46,056,000)
State integrity activities.....	(247,517,000)	(285,120,000)	(294,474,000)	(285,120,000)	(+37,603,000)	(-9,354,000)
National Activities.....	(5,500,000)	(6,366,000)	(6,366,000)	(6,366,000)	(+866,000)	---
Contingency.....	(290,385,000)	(281,219,000)	(247,509,000)	(247,509,000)	(-42,876,000)	(-33,710,000)
Subtotal, Unemployment Compensation(trust funds)	(1,801,075,000)	(1,930,400,000)	(1,952,100,000)	(1,942,746,000)	(+141,671,000)	(-9,354,000)
Employment Service:						
Allotments to States:						
Federal funds.....	20,800,000	21,700,000	21,700,000	21,700,000	+900,000	---
Trust funds.....	(758,239,000)	(700,900,000)	(803,300,000)	(803,300,000)	(+45,061,000)	(+102,400,000)
Subtotal.....	779,039,000	722,600,000	825,000,000	825,000,000	+45,961,000	+102,400,000
National Activities:						
Federal funds.....	1,200,000	1,400,000	3,900,000	1,400,000	+200,000	-2,500,000
Trust funds 3/.....	(42,799,000)	(45,000,000)	(45,000,000)	(70,000,000)	(+27,201,000)	(+25,000,000)
Advance funding for FY 1991.....	(12,500,000)	---	---	---	(-12,500,000)	---
Targeted jobs tax credit.....	(24,653,000)	---	DEFER	(20,000,000)	(-4,653,000)	(+20,000,000)

1/ Senate recommendation includes \$18,882,000 for automation activities, available for obligation April 1, 1991.

2/8111 language would make funds available only for unanticipated workload increases over and above mid-session review projections.

3/ Recommendation includes \$25,000,000 not available for obligation until Oct 1, 1991 for computer opera

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House B111	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House B111
Subtotal, Employment Service.....	835,538,000	799,000,000	873,900,000	896,400,000	+60,862,000	+127,400,000	+22,500,000
Federal funds.....	22,000,000	23,100,000	25,600,000	23,100,000	+1,100,000	---	+2,500,000
Trust funds.....	(901,038,000)	(745,900,000)	(848,300,000)	(873,300,000)	(+72,262,000)	(+127,400,000)	(+23,000,000)
Advance funding for FY 1991.....	(12,500,000)	---	---	---	(-12,500,000)	---	---
Total, State Unemployment 1/.....	2,636,613,000	2,699,400,000	2,826,000,000	2,839,146,000	+202,533,000	+139,746,000	+13,146,000
Federal Funds.....	22,000,000	23,100,000	25,600,000	23,100,000	+1,100,000	---	+2,500,000
Trust Funds.....	(2,602,113,000)	(2,676,300,000)	(2,800,400,000)	(2,816,046,000)	(+213,933,000)	(+139,746,000)	(+15,646,000)
Advance funding for FY 1991.....	(12,500,000)	---	---	---	(-12,500,000)	---	---
Unauthorized, not considered by House.....	(24,653,000)	---	DEFER	(20,000,000)	(-4,653,000)	(+20,000,000)	(+20,000,000)
ADVANCES TO UNEMPLOYMENT TRUST FUND AND OTHER FUNDS....	33,000,000	328,000,000	328,000,000	328,000,000	+295,000,000	---	---
Total, Employment & Training Administration.....	7,353,504,000	7,560,722,000	8,119,968,000	8,071,715,000	+718,211,000	+510,993,000	-48,253,000
Federal funds.....	4,685,777,000	4,830,121,000	5,264,817,000	5,201,368,000	+515,591,000	+371,247,000	-63,449,000
Current year, FY 1990.....	(4,684,277,000)	(4,830,121,000)	(5,264,817,000)	(5,201,368,000)	(+517,091,000)	(+371,247,000)	(-63,449,000)
Advance funding for FY 1991.....	(1,500,000)	---	---	---	(-1,500,000)	---	---
Trust funds.....	(2,655,227,000)	(2,730,601,000)	(2,855,151,000)	(2,870,347,000)	(+215,120,000)	(+139,746,000)	(+15,196,000)
Advance funding for FY 1991.....	(12,500,000)	---	---	---	(-12,500,000)	---	---
Unauthorized, not considered by House.....	(24,653,000)	---	DEFER	(20,000,000)	(-4,653,000)	(+20,000,000)	(+20,000,000)

1/ Includes Federal, Trust and advance Trust funds.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	Budget Request	House B111	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House B111
LABOR - MANAGEMENT SERVICES							
SALARIES AND EXPENSES							
Labor-management relations service.....	5,785,000	5,923,000	5,923,000	5,923,000	+138,000	---	---
Labor-management standards enforcement.....	25,108,000	26,051,000	26,051,000	26,051,000	+943,000	---	---
Pension and welfare benefit programs.....	43,056,000	58,077,000	58,077,000	58,077,000	+15,021,000	---	---
Total, LMSA.....	73,949,000	90,051,000	90,051,000	90,051,000	+16,102,000	---	---
PENSION BENEFIT GUARANTY CORPORATION							
Program Administration subject to limitation (Trust Funds).....	(42,301,000)	(42,669,000)	(42,669,000)	(42,669,000)	(+368,000)	---	---
Other contractual services not subject to limitation (Trust Funds).....	(28,053,000)	(28,459,000)	(28,459,000)	(28,459,000)	(+406,000)	---	---
Total, PBGC (trust funds).....	(70,354,000)	(71,128,000)	(71,128,000)	(71,128,000)	(+774,000)	---	---
EMPLOYMENT STANDARDS ADMINISTRATION							
SALARIES AND EXPENSES							
Enforcement of wage and hour standards.....	90,736,000	93,017,000	93,017,000	93,017,000	+2,281,000	---	---
Federal contractor EEO standards enforcement.....	52,985,000	53,645,000	53,645,000	53,645,000	+660,000	---	---
Federal programs for workers' compensation.....	58,661,000	60,639,000	61,720,000	61,720,000	+3,059,000	+1,081,000	---
Trust funds.....	(1,011,000)	(1,016,000)	(1,016,000)	(1,016,000)	(+5,000)	---	---
Executive direction and support services.....	13,746,000	14,006,000	14,006,000	14,006,000	+260,000	---	---
Total, salaries and expenses.....	217,139,000	222,323,000	223,404,000	223,404,000	+6,265,000	+1,081,000	---
Federal funds.....	216,128,000	221,307,000	222,388,000	222,388,000	+6,260,000	+1,081,000	---
Trust funds.....	(1,011,000)	(1,016,000)	(1,016,000)	(1,016,000)	(+5,000)	---	---

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House Bill	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House Bill
SPECIAL BENEFITS							
Federal employees compensation benefits.....	251,000,000	318,000,000	318,000,000	318,000,000	+67,000,000	---	---
Longshore and harbor workers' benefits.....	4,000,000	4,000,000	4,000,000	4,000,000	---	---	---
Subtotal, current appropriation.....	255,000,000	322,000,000	322,000,000	322,000,000	+67,000,000	---	---
Less appropriation for prior year cost.....	-85,975,000	-25,000,000	-25,000,000	-25,000,000	+60,975,000	---	---
Plus appropriation available from subsequent year.	25,000,000	---	---	---	-25,000,000	---	---
Total, Special Benefits, program level.....	194,025,000	297,000,000	297,000,000	297,000,000	+102,975,000	---	---
BLACK LUNG DISABILITY TRUST FUND							
Benefit payments and interest on advances.....	590,486,000	866,019,000	866,019,000	866,019,000	+275,533,000	---	---
Employment Standards Admin., salaries & expenses.....	28,640,000	29,051,000	29,051,000	29,051,000	+411,000	---	---
Departmental Management, salaries and expenses.....	22,050,000	19,396,000	23,355,000	23,355,000	+1,305,000	+3,959,000	---
Departmental Management, inspector general.....	506,000	371,000	371,000	371,000	-135,000	---	---
Subtotal, Black Lung Disability. Trust Fund, apprn	641,682,000	914,837,000	918,796,000	918,796,000	+277,114,000	+3,959,000	---
Treasury administrative costs (indefinite).....	745,000	756,000	756,000	756,000	+11,000	---	---
Total, Black Lung Disability Trust Fund.....	642,427,000	915,593,000	919,552,000	919,552,000	+277,125,000	+3,959,000	---
Total, Employment Standards Administration.....	1,053,591,000	1,434,916,000	1,439,956,000	1,439,956,000	+386,365,000	+5,040,000	---
Federal funds.....	1,052,580,000	1,433,900,000	1,438,940,000	1,438,940,000	+386,360,000	+5,040,000	---
Trust funds.....	(1,011,000)	(1,016,000)	(1,016,000)	(1,016,000)	(-5,000)	---	---

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

TITLE 11--DEPARTMENT OF HEALTH AND HUMAN SERVICES	FY 1990		FY 1991	Senate	Senate	
	Comparable	Budget Request			House B111	Recommendation	compared with FY 1991 Budget	House B111
HEALTH RESOURCES AND SERVICES ADMINISTRATION						
HEALTH RESOURCES AND SERVICES						
Health Care Delivery and Assistance:						
Community health centers.....	456,914,000	471,785,000	490,000,000	477,000,000	+20,086,000	+5,215,000
Migrant health.....	49,343,000	50,601,000	52,000,000	54,000,000	+4,657,000	+3,399,000
Black lung clinics.....	3,651,000	3,651,000	3,800,000	3,800,000	+149,000	+149,000
Health care for the homeless.....	35,967,000	33,667,000	40,000,000	40,000,000	+4,033,000	+6,333,000
Advance funding for FY 1991.....	11,885,000	---	---	---	-11,885,000	---
Family planning 1/.....	(139,135,000)	(139,135,000)	DEFER	(148,000,000)	(+8,865,000)	(+148,000,000)
National Health Service Corps:						
Field placements.....	(41,837,000)	(42,361,000)	DEFER	(44,000,000)	(+2,163,000)	(+1,639,000)
Loan repayments including nurses.....	(5,921,000)	(8,882,000)	DEFER	(8,882,000)	(+2,961,000)	---
Scholarships.....	(2,961,000)	(55,000,000)	DEFER	(55,000,000)	(+52,039,000)	---
Subtotal, Natl Health Service Corps.....	(50,719,000)	(106,243,000)	DEFER	(107,882,000)	(+57,163,000)	(+107,882,000)
Hansen's Disease services (Carville).....	18,158,000	22,601,000	20,601,000	20,601,000	+2,443,000	-2,000,000
Payment to Hawaii, treatment of Hansen's Disease..	3,217,000	3,217,000	3,300,000	3,467,000	+250,000	+250,000
Home health demonstration grants.....	2,961,000	---	---	3,211,000	+250,000	+3,211,000
Total, Health Care Delivery & Assistance.....	582,096,000	585,522,000	609,701,000	602,079,000	+19,983,000	+16,557,000
						-7,622,000

1/ President's FY 1991 budget requests Family Planning under "Public Health Service Management" account.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House Bill Recommendation	FY 1990	Senate Compared with FY 1991 Budget	House Bill
Health Professions:						
Exceptional need scholarships.....	6,695,000	10,000,000	10,000,000	+3,315,000	---	---
Excellence in minority health education grants	9,231,000	12,000,000	12,000,000	+2,769,000	---	---
Public health/health administration:						
Public health capitalization.....	2,948,000	---	---	-2,948,000	---	---
Public Health special projects.....	834,000	---	3,300,000	+3,566,000	+4,400,000	+1,100,000
Health Administration grants.....	1,483,000	---	1,483,000	+217,000	+1,700,000	+217,000
Public Health traineeships.....	2,987,000	---	3,500,000	+513,000	+3,500,000	---
Health Administration traineeships.....	492,000	---	492,000	+8,000	+500,000	+8,000
Preventive medicine residencies.....	1,695,000	---	1,695,000	---	+1,695,000	---
Family Medicine.....	32,761,000	---	37,000,000	32,761,000	+32,761,000	-4,239,000
General dentistry residencies.....	3,929,000	---	3,929,000	---	+3,929,000	---
General Internal Medicine and Pediatrics.....	17,682,000	---	17,682,000	---	+17,682,000	---
Family medicine departments.....	6,680,000	---	7,000,000	6,680,000	+6,680,000	-320,000
Physician assistants.....	4,789,000	---	4,789,000	+711,000	+5,500,000	+711,000
Area health education centers.....	18,125,000	---	18,125,000	+1,875,000	+20,000,000	+1,875,000
Health education and training centers.....	3,929,000	---	3,929,000	+71,000	+4,000,000	+71,000
Health professions data analysis.....	1,846,000	---	1,846,000	---	+1,846,000	---
Disadvantaged Assistance.....	26,965,000	31,578,000	31,578,000	+4,613,000	---	---
Allied health grants and contracts.....	737,000	---	1,400,000	+1,263,000	+2,000,000	+600,000
Interdisciplinary traineeships.....	2,210,000	---	---	+3,790,000	+6,000,000	+6,000,000

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House B111	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House B111
Special Projects: (sections 788, 789 and 301)							
Health professions special initiatives.....	2,457,000	---	2,457,000	2,457,000	---	+2,457,000	---
Geriatric training and research.....	14,047,000	---	14,047,000	14,047,000	---	+14,047,000	---
Health Services outreach grants.....	---	---	DEFER	(20,000,000)	(+20,000,000)	(+20,000,000)	(+20,000,000)
Pacific Basin activities (Including Medical Officer training).....	1,974,000	---	---	2,500,000	+526,000	+2,500,000	+2,500,000
Native Hawaiian health care.....	1,283,000	1,283,000	1,283,000	4,000,000	+2,717,000	+2,717,000	+2,717,000
Subtotal, special education initiatives.....	19,761,000	1,283,000	17,787,000	23,004,000	+3,243,000	+21,721,000	+5,217,000
Special grants to hospitals.....	1,343,000	---	---	---	-1,343,000	---	---
Nurse training:							
Advanced nurse education.....	12,771,000	---	12,771,000	12,771,000	---	+12,771,000	---
Nurse practitioners.....	13,432,000	---	13,432,000	15,432,000	+2,000,000	+15,432,000	+2,000,000
Special projects.....	10,283,000	---	10,283,000	11,300,000	+1,017,000	+11,300,000	+1,017,000
Traineeships.....	13,501,000	---	13,501,000	14,501,000	+1,000,000	+14,501,000	+1,000,000
Nurse Anesthetists.....	1,130,000	---	1,130,000	1,800,000	+670,000	+1,800,000	+670,000
Undergraduate scholarships.....	2,948,000	---	2,948,000	1,930,000	-1,018,000	+1,930,000	-1,018,000
Loan Repayment for Shortage Area Service.....	982,000	---	982,000	2,000,000	+1,018,000	+2,000,000	+1,018,000
Nurse disadvantaged assistance.....	2,571,000	4,000,000	4,000,000	3,000,000	+429,000	-1,000,000	-1,000,000
Subtotal, nurse training.....	57,616,000	4,000,000	59,047,000	62,734,000	+5,116,000	+58,734,000	+3,687,000
Less transfers from loan revolving funds.....	-10,000,000	---	-10,000,000	---	+10,000,000	---	+10,000,000
Total, Health professions.....	214,730,000	58,861,000	226,582,000	251,509,000	+36,779,000	+192,648,000	+24,927,000

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House Bill Recommendation	FY 1990	Senate compared with FY 1991 Budget	House Bill
MCH and Resources Development:						
Maternal & child health block grant.....	553,627,000	578,627,000	598,627,000	+51,373,000	+26,373,000	+6,373,000
Pediatric emergency care.....	3,947,000	---	---	+1,053,000	+5,000,000	+5,000,000
Organ transplantation.....	3,948,000	3,257,000	4,257,000	-491,000	+200,000	-800,000
Health teaching facilities interest subsidies.....	488,000	488,000	488,000	---	---	---
Total, Resources Development.....	562,010,000	582,372,000	603,372,000	+51,935,000	+31,573,000	+10,573,000
Buildings and facilities.....	877,000	---	2,000,000	+1,123,000	+2,000,000	---
National practitioner data bank.....	1,974,000	1,974,000	1,974,000	---	---	---
Proposed user fees.....	---	-1,974,000	---	---	+1,974,000	---
Rural health research.....	3,380,000	4,380,000	4,380,000	+2,120,000	+1,120,000	+1,120,000
Minority health initiatives:						
HRD health services grant.....	---	(35,000,000)	DEFER	---	(-35,000,000)	---
Disadvantaged min. health improvement.....	---	(17,000,000)	DEFER	---	(-17,000,000)	---
Subtotal.....	---	(52,000,000)	DEFER	---	(-52,000,000)	---

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House B111 Recommendation	FY 1990	Senate compared with FY 1991 Budget	House B111
Acquired Immune Deficiency Syndrome (AIDS):						
Training of health personnel.....	14,549,000	21,000,000	17,500,000	+2,951,000	-3,500,000	---
Facilities renovation grants.....	4,342,000	4,129,000	4,129,000	---	-4,129,000	-4,129,000
Pediatric health care demonstrations.....	14,803,000	14,803,000	20,000,000	---	-14,803,000	-20,000,000
Adult health care demonstrations.....	17,209,000	19,424,000	27,200,000	---	-17,209,000	-27,200,000
AIDS related drugs (AZT).....	(29,606,000)	---	DEFER	---	(-29,606,000)	---
Community health care services.....	10,777,000	13,323,000	13,323,000	---	-10,777,000	-13,323,000
Home health services.....	19,737,000	---	---	---	-19,737,000	---
Subacute care.....	1,480,000	---	---	---	-1,480,000	---
Emergency assistance:						
1991.....	---	---	---	49,000,000	+49,000,000	+49,000,000
1992 1/.....	---	---	---	251,000,000	+251,000,000	+251,000,000
Transfer for consolidated administration.....	-4,786,000	-4,786,000	-4,786,000	---	+4,786,000	+4,786,000
Comprehensive care programs:						
1991.....	---	---	---	110,000,000	+110,000,000	+110,000,000
1992 1/2.....	---	---	---	190,000,000	+190,000,000	+190,000,000
Subtotal, AIDS.....	78,111,000	67,893,000	77,366,000	+539,389,000	+549,607,000	+540,134,000
Program management including AIDS.....	98,170,000	99,551,000	102,000,000	104,551,000	+6,381,000	+2,551,000
Total, Health resources and services.....	1,541,348,000	1,398,579,000	1,627,375,000	2,199,050,000	+867,710,000	+571,683,000
Unauthorized, not considered by House.....	(219,460,000)	(297,378,000)	DEFER	(275,882,000)	(-56,422,000)	(-21,496,000)
Total, authorized and unauthorized.....	(1,760,808,000)	(1,695,957,000)	(1,627,375,000)	(2,474,940,000)	(-778,983,000)	(-847,565,000)

1/ Available for obligation October 1, 1991.
 2/ Available for obligation October 1, 1991.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	Budget Request	House 8111	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House 8111
MEDICAL FACILITIES GUARANTEE AND LOAN FUND:							
Interest subsidy program.....	21,000,000	20,000,000	20,000,000	20,000,000	-1,000,000	---	---
HEALTH PROFESSIONS GRADUATE STUDENT LOAN FUND (HEAL): 1/							
General funds.....	24,870,000	---	---	---	-24,870,000	---	---
VACCINE INJURY COMPENSATION:							
Pre - FY89 claims (appropriation).....	74,500,000	---	62,920,000	62,920,000	-11,580,000	+62,920,000	---
FY89 / FY90 claims (trust fund).....	139,700,000	221,500,000	154,080,000	154,080,000	+14,380,000	-67,420,000	---
HRSA administration (trust fund).....	---	---	1,500,000	1,500,000	+1,500,000	+1,500,000	---
Subtotal.....	214,200,000	221,500,000	218,500,000	218,500,000	+4,300,000	-3,000,000	---
Total, Health Resources and Services Administration.....	1,801,418,000	1,640,079,000	1,865,875,000	2,437,558,000	+636,140,000	+797,475,000	+571,883,000
Current year.....	(1,789,533,000)	(1,640,079,000)	(1,865,875,000)	(1,996,558,000)	(+207,025,000)	(+356,475,000)	(+130,683,000)
Advance funding for FY 1991.....	(11,885,000)	---	---	(441,000,000)	(+429,115,000)	(+441,000,000)	(+441,000,000)
Unauthorized, not considered by House.....	(219,460,000)	(297,378,000)	DEFER	(275,882,000)	(+56,422,000)	(-21,496,000)	(+275,882,000)
Total, authorized and unauthorized.....	(2,020,878,000)	(1,937,457,000)	(1,865,875,000)	(2,713,440,000)	(+692,562,000)	(+775,983,000)	(+847,565,000)

1/ President's budget requests authority to transfer \$15 million in other Health Resources and Services unobligated balances to this account.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House 8111	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House 8111
HEALTH CARE FINANCING ADMINISTRATION							
GRANTS TO STATES FOR MEDICAID 1/							
Medicaid current law benefits.....	38,214,759,000	42,868,526,000	42,868,526,000	45,219,954,000	+7,005,195,000	+2,351,428,000	+2,351,428,000
State and local administration.....	2,014,743,000	2,146,440,000	2,146,440,000	2,146,440,000	+131,697,000	---	---
Proposed legislation, user fees.....	---	-113,457,000	---	---	---	+113,457,000	---
Proposed legislation, user fees.....	---	---	---	-85,093,000	-85,093,000	-85,093,000	-85,093,000
Subtotal, Medicaid program level, FY 1991.....	40,229,502,000	44,901,509,000	45,014,966,000	47,281,301,000	+7,051,799,000	+2,379,792,000	+2,266,335,000
Less funds advanced in prior year.....	-9,000,000,000	-10,400,000,000	-10,400,000,000	-10,400,000,000	-1,400,000,000	---	---
Total, current request, FY 1991.....	31,229,502,000	34,501,509,000	34,614,966,000	36,881,301,000	+5,651,799,000	+2,379,792,000	+2,266,335,000
New advance, 1st quarter, FY 1992.....	10,400,000,000	12,400,000,000	12,400,000,000	13,500,000,000	+3,100,000,000	+1,100,000,000	+1,100,000,000
PAYMENTS TO HEALTH CARE TRUST FUNDS							
Supplemental medical insurance.....	35,925,500,000	36,451,000,000	36,451,000,000	34,730,000,000	-1,195,500,000	-1,721,000,000	-1,721,000,000
Hospital insurance for uninsured.....	378,000,000	559,000,000	559,000,000	559,000,000	+181,000,000	---	---
Federal uninsured payment.....	35,000,000	46,000,000	46,000,000	46,000,000	+11,000,000	---	---
Total, Payment to Trust Funds 2/.....	36,338,500,000	37,056,000,000	37,056,000,000	35,335,000,000	-1,003,500,000	-1,721,000,000	-1,721,000,000

1/ Excludes \$25,000,000 in legislative additions proposed for later transmittal.

2/ Excludes legislative savings of \$1,981 million proposed for later transmittal.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

SOCIAL SECURITY ADMINISTRATION

	FY 1990 Comparable	FY 1991 Budget Request	House B111 Recommendation	FY 1990	Senate compared with FY 1991 Budget	House B111
PAYMENTS TO SOCIAL SECURITY TRUST FUNDS.....	191,968,000	46,958,000	46,958,000	-145,010,000	---	---
SPECIAL BENEFITS FOR DISABLED COAL MINERS						
Benefit payments.....	863,422,000	834,000,000	834,000,000	-29,422,000	---	---
Administration.....	6,831,000	7,081,000	7,081,000	+250,000	---	---
Subtotal, Black Lung, FY 1991 program level.....	870,253,000	841,081,000	841,081,000	-29,172,000	---	---
Less funds advanced in prior year.....	-211,000,000	-215,000,000	-215,000,000	-4,000,000	---	---
Total, Black Lung, current request, FY 1991.....	659,253,000	626,081,000	626,081,000	-33,172,000	---	---
New advance, 1st quarter, FY 1992.....	215,000,000	203,000,000	203,000,000	-12,000,000	---	---

SUPPLEMENTAL SECURITY INCOME 1/

Federal benefit payments.....	11,185,613,000	13,913,000,000	13,913,000,000	15,935,000,000	+2,022,000,000	+2,022,000,000
Beneficiary services.....	13,739,000	27,717,000	27,717,000	32,517,000	+4,800,000	+4,800,000
Research demonstration.....	5,275,000	2,275,000	5,275,000	9,275,000	+7,000,000	+4,000,000
Administration.....	1,090,131,000	1,212,602,000	1,212,602,000	1,134,826,000	+44,695,000	-77,776,000
Subtotal, SSI FY 1991 program level.....	12,294,758,000	15,155,594,000	15,158,594,000	17,111,618,000	+1,956,024,000	+1,953,024,000
Less funds advanced in prior year.....	-2,936,000,000	-3,157,000,000	-3,157,000,000	-221,000,000	---	---
Total, SSI, current request, FY 1991.....	9,358,758,000	11,998,594,000	12,001,594,000	+4,595,860,000	+1,956,024,000	+1,953,024,000
New advance, 1st quarter, FY 1992.....	3,157,000,000	3,550,000,000	3,550,000,000	+393,000,000	---	---
LIMITATION ON ADMINISTRATIVE EXPENSES (Trust Funds)...	(3,837,389,000)	(4,166,974,000)	(4,166,974,000)	(4,316,974,000)	(+150,000,000)	(+150,000,000)
(Contingency reserve, non-add).....	(50,000,000)	(50,000,000)	(50,000,000)	(200,000,000)	(+150,000,000)	(+150,000,000)

Total, Social Security Administration:

Federal funds.....	13,581,979,000	16,424,633,000	16,427,633,000	18,390,657,000	+1,956,024,000	+1,953,024,000
Current year FY 1991.....	(10,209,979,000)	(12,671,633,000)	(12,674,633,000)	(14,627,657,000)	(+4,417,678,000)	(+1,953,024,000)
New advances, 1st quarter FY 1992.....	(3,372,000,000)	(3,753,000,000)	(3,753,000,000)	(3,753,000,000)	---	---
Trust funds.....	(3,837,389,000)	(4,166,974,000)	(4,166,974,000)	(4,316,974,000)	(+150,000,000)	(+150,000,000)

1/ Excludes \$55,000,000 in legislative savings proposed for later transmittal.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House B111 Recommendation	Senate compared with FY 1991 Budget	House B111
FAMILY SUPPORT ADMINISTRATION 1/					
FAMILY SUPPORT PAYMENTS TO STATES 2/					
Aid to Families with Dependent Children (AFDC).....	9,261,706,000	9,999,000,000	9,999,000,000	10,521,000,000	+1,259,294,000
Payments to territories.....	16,346,000	16,346,000	16,346,000	16,346,000	---
Emergency assistance, incl. welfare hotel demos.....	204,000,000	194,000,000	194,000,000	204,700,000	+700,000
Repatriation.....	1,000,000	1,000,000	1,000,000	1,000,000	---
State and local welfare administration.....	1,504,500,000	1,471,900,000	1,471,900,000	1,496,300,000	+24,400,000
Work activities / child care.....	206,000,000	489,000,000	489,000,000	412,000,000	-77,000,000
Regulatory savings.....	---	-35,000,000	-35,000,000	---	+35,000,000
Subtotal, Welfare payments.....	11,193,552,000	12,136,246,000	12,136,246,000	12,651,346,000	+515,100,000
Child Support Enforcement:					
State and local administration.....	1,059,600,000	1,197,000,000	1,197,000,000	1,197,000,000	---
Federal incentive payments.....	276,000,000	332,000,000	332,000,000	332,000,000	---
Less federal share collections.....	-836,000,000	-1,008,000,000	-1,008,000,000	-1,008,000,000	---
Subtotal, Child support.....	499,600,000	521,000,000	521,000,000	521,000,000	---
Total, Payments, FY 1991 program level.....	11,692,552,000	12,657,246,000	12,657,246,000	13,172,346,000	+515,100,000
Less funds advanced in previous years.....	-2,700,000,000	-3,000,000,000	-3,000,000,000	-3,000,000,000	---
Total, Payments, current request, FY 1991.....	8,992,552,000	9,657,246,000	9,657,246,000	10,172,346,000	+515,100,000
New advance, 1st quarter, FY 1992.....	3,000,000,000	3,300,000,000	3,300,000,000	3,300,000,000	---

1/ Excludes Administration proposal to shift USDA
Fiscal Assistance to Puerto Rico Program to FSA.
2/ Excludes legislative savings of \$32.4 million
proposed for later transmittal.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House Bill	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House Bill
PAYMENTS TO STATES FOR AFDC WORK PROGRAMS 1/							
New Jobs Activities program 2/.....	443,038,000	1,000,000,000	1,000,000,000	1,006,500,000	+563,462,000	+6,500,000	+6,500,000
WIA Phaseout.....	31,200,000	---	---	---	-31,200,000	---	---
Total, AFDC work programs.....	474,238,000	1,000,000,000	1,000,000,000	1,006,500,000	+532,262,000	+6,500,000	+6,500,000
LOW INCOME HOME ENERGY ASSISTANCE							
Energy Assistance Block Grant 3/.....	(1,393,000,000)	(1,050,000,000)	DEFER	(1,450,000,000)	(+57,000,000)	(+400,000,000)	(+1,450,000,000)
One time emergency grants.....	(50,000,000)	---	DEFER	---	(-50,000,000)	---	---
Total, Low income home energy assistance.....	(1,443,000,000)	(1,050,000,000)	DEFER	(1,450,000,000)	(+7,000,000)	(+400,000,000)	(+1,450,000,000)
ENERGY EMERGENCY CONTINGENCY FUND							
Energy Emergency Contingency Fund.....	---	---	---	(200,000,000)	(+200,000,000)	(+200,000,000)	(+200,000,000)
REFUGEE AND ENTRANT ASSISTANCE							
Cash and medical assistance 4/.....	(210,000,000)	(210,000,000)	DEFER	(210,000,000)	---	---	(+210,000,000)
Social services.....	(75,000,000)	(75,000,000)	DEFER	(85,000,000)	(+10,000,000)	(+10,000,000)	(+85,000,000)
Voluntary agency program.....	(40,000,000)	(40,000,000)	DEFER	(45,000,000)	(+5,000,000)	(+5,000,000)	(+45,000,000)
Preventive health.....	(5,770,000)	(5,770,000)	DEFER	(8,000,000)	(+2,230,000)	(+2,230,000)	(+8,000,000)
Targeted assistance.....	(44,052,000)	(38,052,000)	DEFER	(50,000,000)	(+5,948,000)	(+11,948,000)	(+50,000,000)
Total, Refugee Resettlement.....	(374,822,000)	(368,822,000)	DEFER	(398,000,000)	(+23,178,000)	(+29,178,000)	(+398,000,000)
STATE LEGALIZATION IMPACT ASSISTANCE GRANTS							
FY 1990 enacted 5/.....	-567,424,000	---	---	-566,854,000	+570,000	-566,854,000	-566,854,000
FY 1991 request (non-add).....	---	(-537,403,000)	---	---	---	(+537,403,000)	---
FY 1990 enacted for FY 1992 6/.....	555,244,000	---	---	579,034,000	+23,790,000	+579,034,000	+579,034,000
FY 1992 request (non-add).....	---	(-555,244,000)	---	---	---	(+555,244,000)	---

1/ Reflects reprogramming approved 4/11/90.

2/ Senate Recommendation includes \$6,500,000 for job creation demos authorized under section 505 of the Family Support Act.

3/ Senate recommendation includes \$74,610,000 for obligation September 30, 1991.

4/ Includes State administrative costs.

5/ Senate recommendation represents reduction of Fiscal 1991 permanent appropriation.

6/ Senate recommendation represents increase of Fiscal 1992 permanent appropriation.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

COMMUNITY SERVICES BLOCK GRANT

	FY 1990 Comparable	FY 1991 Budget Request	House B111	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House B111
Grants to States for Community Services.....	(323,085,000)	---	DEFER	(368,000,000)	(+44,915,000)	(+368,000,000)	(+368,000,000)
Homeless services grants.....	(21,855,000)	(33,959,000)	DEFER	(34,000,000)	(+12,145,000)	(+41,000)	(+34,000,000)
Advance funding for FY 1991.....	(8,041,000)	---	DEFER	---	(-8,041,000)	---	---
Discretionary funds:							
Community economic development.....	(20,158,000)	---	DEFER	(21,000,000)	(+842,000)	(+21,000,000)	(+21,000,000)
Rural housing.....	(3,994,000)	---	DEFER	(4,200,000)	(+206,000)	(+4,200,000)	(+4,200,000)
Farworker assistance.....	(2,934,000)	---	DEFER	(3,100,000)	(+166,000)	(+3,100,000)	(+3,100,000)
National youth sports, regular activities.....	(10,618,000)	---	DEFER	(11,100,000)	(+482,000)	(+11,100,000)	(+11,100,000)
Technical assistance.....	(235,000)	---	DEFER	(250,000)	(+15,000)	(+250,000)	(+250,000)
Subtotal, discretionary funds.....	(37,939,000)	---	DEFER	(39,650,000)	(+1,711,000)	(+39,650,000)	(+39,650,000)
Community Partnerships.....	(3,495,000)	---	DEFER	(4,150,000)	(+655,000)	(+4,150,000)	(+4,150,000)
Community Food and Nutrition.....	(2,406,000)	---	DEFER	(2,500,000)	(+94,000)	(+2,500,000)	(+2,500,000)
Total, Community services.....	(396,821,000)	(33,959,000)	DEFER	(448,300,000)	(+51,479,000)	(+414,341,000)	(+448,300,000)

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House B111 Recommendation	FY 1990	Senate compared with FY 1991 Budget	House B111
PROGRAM ADMINISTRATION						
Federal Administration.....	75,628,000	74,950,000	74,950,000	-178,000	+500,000	+500,000
Proposed user fees.....	---	-2,000,000	-1,000,000	-1,000,000	+1,000,000	---
Research & evaluation.....	9,825,000	4,250,000	6,250,000	-1,075,000	+4,500,000	+2,500,000
Total, program administration.....	85,453,000	77,200,000	80,200,000	-2,253,000	+6,000,000	+3,000,000
Total, Family Support Administration.....	12,540,063,000	14,034,446,000	14,037,446,000	+2,034,163,000	+539,780,000	+536,780,000
Current year.....	(8,984,819,000)	(10,734,446,000)	(10,737,446,000)	(+1,710,373,000)	(-39,254,000)	(-42,254,000)
FY 1992.....	(3,555,244,000)	(3,300,000,000)	(3,300,000,000)	(+323,790,000)	(+579,034,000)	(+579,034,000)
Unauthorized, not considered by House.....	(2,214,643,000)	(1,452,781,000)	DEFER	(+81,657,000)	(+843,519,000)	(+2,296,300,000)
Total, authorized and unauthorized.....	(14,754,706,000)	(15,487,227,000)	(14,037,446,000)	(+2,115,620,000)	(+1,383,299,000)	(+2,833,880,000)

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House B111	Senate Recommendation	FY 1990	Senate Compare with FY 1991 Budget	House B111
ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES							
SOCIAL SERVICES BLOCK GRANT (TITLE XX).....	2,762,200,000	2,800,000,000	2,800,000,000	2,800,000,000	+37,800,000	---	---
HUMAN DEVELOPMENT SERVICES							
Programs for Children, Youth, and Families:							
Head Start.....	(1,552,000,000)	(1,886,315,000)	DEFER	(2,000,000,000)	(+448,000,000)	(+113,685,000)	(+2,000,000,000)
Child development associate scholarships.....	(1,431,000)	(1,431,000)	DEFER	(1,431,000)	---	---	(+1,431,000)
Family crisis program:							
Child abuse state grants.....	11,567,000	11,523,000	20,000,000	20,000,000	+8,433,000	+8,477,000	---
Child abuse challenge grants.....	4,934,000	4,934,000	5,000,000	5,500,000	+566,000	+566,000	+500,000
Runaway and homeless youth.....	28,785,000	28,785,000	36,000,000	36,000,000	+7,215,000	+7,215,000	---
Family violence.....	8,273,000	8,273,000	13,273,000	11,000,000	+2,727,000	+2,727,000	-2,273,000
Abandoned infants assistance.....	9,867,000	9,867,000	9,867,000	12,867,000	+3,000,000	+3,000,000	+3,000,000
Emergency protection grants - substance abuse.	---	---	20,000,000	---	---	---	-20,000,000
Subtotal, family crisis.....							
	63,426,000	63,362,000	104,140,000	85,367,000	+21,941,000	+21,985,000	-18,773,000
Dependent care planning and development.....	(13,178,000)	(13,178,000)	DEFER	(13,500,000)	(+322,000)	(+322,000)	(+13,500,000)
Child welfare assistance.....	252,648,000	252,648,000	280,000,000	252,648,000	---	---	-27,352,000
Proposed legislation.....	---	47,352,000	---	---	---	-47,352,000	---
Subtotal.....							
	316,074,000	363,362,000	384,140,000	338,015,000	+21,941,000	-25,367,000	-46,125,000

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House 8111 Recommendation	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House 8111
Programs for the Aging:							
Grants to States:							
Supportive Services and Centers.....	271,987,000	272,961,000	298,000,000	298,000,000	+26,013,000	+25,039,000	---
Ombudsman activities.....	973,000	---	3,000,000	6,000,000	+5,027,000	+6,000,000	+3,000,000
Nutrition:							
Congregate meals.....	351,925,000	351,925,000	370,000,000	370,000,000	+18,075,000	+18,075,000	---
Home-delivered meals.....	78,981,000	78,981,000	90,000,000	90,000,000	+11,019,000	+11,019,000	---
Federal Council on Aging 1/.....	---	---	185,000	---	---	---	-185,000
Grants to Indians.....	12,541,000	12,541,000	14,000,000	16,000,000	+3,459,000	+3,459,000	+2,000,000
Fraill elderly in-home services.....	5,756,000	5,756,000	5,756,000	7,000,000	+1,244,000	+1,244,000	+1,244,000
Subtotal, Aging programs.....	722,163,000	722,164,000	780,941,000	787,000,000	+64,837,000	+64,836,000	+6,059,000
Developmental disabilities program:							
State grants.....	(61,939,000)	(61,939,000)	DEFER	(66,000,000)	(+4,061,000)	(+4,061,000)	(+66,000,000)
Protection and advocacy.....	(20,484,000)	(20,484,000)	DEFER	(21,500,000)	(+1,016,000)	(+1,016,000)	(+21,500,000)
Subtotal, Developmental disabilities.....	(82,423,000)	(82,423,000)	DEFER	(87,500,000)	(+5,077,000)	(+5,077,000)	(+87,500,000)
Native American Programs.....	31,711,000	31,711,000	34,200,000	34,200,000	+2,489,000	+2,489,000	---
1/ President's budget proposes to fund under Program Direction.							

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House Bill Recommendation	FY 1990	Senate compared with FY 1991 Budget	House Bill
Human services research, training & demonstration: Comprehensive child development centers.....	24,668,000	24,668,000	24,668,000	25,000,000	+332,000	+332,000
Child abuse discretionary activities.....	13,478,000	13,523,000	15,000,000	15,000,000	+1,572,000	---
Runaway youth - transitional living.....	9,867,000	9,867,000	9,867,000	10,500,000	+633,000	+633,000
Runaway youth activities - drugs.....	14,801,000	14,801,000	14,801,000	15,500,000	+699,000	+699,000
Youth gang substance abuse.....	14,801,000	14,801,000	14,801,000	15,500,000	+699,000	+699,000
Temporary childcare/crisis nurseries.....	8,328,000	8,328,000	8,328,000	11,328,000	+3,000,000	+3,000,000
Child welfare training.....	3,647,000	3,647,000	3,647,000	---	---	---
Child welfare research 1/.....	7,517,000	13,517,000	13,517,000	8,000,000	+483,000	-5,517,000
Adoption opportunities.....	6,736,000	6,736,000	13,000,000	13,000,000	+6,264,000	+6,264,000
Aging research, training and special projects.....	25,332,000	26,332,000	27,332,000	27,832,000	+2,500,000	+500,000
Social services research.....	3,475,000	3,475,000	3,975,000	3,975,000	+500,000	+500,000
Developmental disabilities special projects.....	(2,862,000)	(2,862,000)	DEFER	(3,100,000)	(+238,000)	(+3,100,000)
Developmental disabilities university affiliated programs.....	(13,192,000)	(13,192,000)	DEFER	(14,250,000)	(+1,058,000)	(+14,250,000)
Total, Human Services Res, Trng & demonstration.	132,650,000	139,695,000	149,936,000	149,282,000	+16,632,000	+346,000
Program direction 2/.....	68,313,000	71,149,000	75,000,000	73,000,000	+4,687,000	-2,000,000
Subtotal, Human Development Services.....	1,270,911,000	1,328,101,000	1,423,217,000	1,381,497,000	+110,586,000	+53,396,000
Child care: FY 1991 3/.....	---	---	---	1,159,000,000	+1,159,000,000	+1,159,000,000
FY 1992 4/.....	---	---	---	41,000,000	+41,000,000	+41,000,000
Total, Human Development Services.....	1,270,911,000	1,328,101,000	1,423,217,000	2,540,497,000	+1,269,586,000	+1,212,396,000
Unauthorized, not considered by House.....	(1,665,086,000)	(1,999,401,000)	DEFER	(2,119,781,000)	(+454,695,000)	(+120,360,000)
Total, authorized and unauthorized.....	(2,935,997,000)	(3,327,502,000)	(1,423,217,000)	(4,701,278,000)	(+1,765,281,000)	(+3,278,061,000)

1/ Senate recommendation provides \$6,000,000 for crack babies under temporary child care/crisis nurseries and abandoned infants.

2/ Includes funding for the Federal Council on Aging.

3/ Available for obligation September 15, 1991.

4/ Available for obligation October 1, 1991.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House Bill Recommendation	FY 1990	Senate compared with FY 1991 Budget	House Bill
PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE						
Foster care.....	1,200,061,000	1,877,712,000	1,877,712,000	1,840,538,000	+640,477,000	-37,174,000
Proposed legislation.....	---	-160,909,000	---	---	+160,909,000	---
Adoption assistance.....	124,855,000	150,480,000	150,480,000	189,832,000	+64,977,000	+39,352,000
Independent living.....	50,000,000	60,000,000	60,000,000	60,000,000	+10,000,000	---
Prior year claims.....	---	544,000,000	544,000,000	520,911,000	+520,911,000	-23,089,000
Total, Payments to States.....	1,374,916,000	2,471,283,000	2,632,192,000	2,611,261,000	+1,236,365,000	-20,911,000
Total, Asst. Sec. for Human Development.....	5,408,027,000	6,599,384,000	6,855,409,000	7,951,778,000	+2,543,751,000	+1,096,369,000
Unauthorized, not considered by House.....	(1,665,086,000)	(1,999,401,000)	DEFER	(2,119,781,000)	(+454,695,000)	(+2,119,781,000)

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

SUMMARY

	FY 1990 Comparable	FY 1991 Budget Request	House 8111	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House 8111
Title I - Department of Labor:							
Federal Funds.....	6,599,016,000	7,195,375,000	7,648,593,000	7,582,271,000	+983,255,000	+386,946,000	-66,322,000
Current year.....	(6,597,516,000)	(7,195,375,000)	(7,648,593,000)	(7,582,271,000)	(+984,755,000)	(+386,946,000)	(-66,322,000)
1992 advance.....	(1,500,000)	---	---	---	(-1,500,000)	---	---
Unauthorized, not considered by House.....	(11,343,000)	(11,500,000)	DEFER	(11,500,000)	(+157,000)	---	(+11,500,000)
Total, authorized and unauthorized.....	(6,610,359,000)	(7,206,875,000)	DEFER	(7,593,771,000)	(+983,412,000)	(+386,946,000)	(-54,822,000)
Trust Funds.....	(2,941,886,000)	(3,016,439,000)	(3,156,566,000)	(3,171,212,000)	(+229,326,000)	(+154,773,000)	(+14,646,000)
1991 advance.....	(12,500,000)	---	---	---	(-12,500,000)	---	---
Unauthorized, not considered by House.....	(24,653,000)	---	DEFER	(20,000,000)	(-4,653,000)	(+20,000,000)	(+20,000,000)
Title II - Department of Health and Human Services:							
Federal Funds (all years).....	122,510,968,000	134,476,996,000	135,926,008,000	141,558,942,000	+19,047,974,000	+7,081,946,000	+5,632,934,000
Current year.....	(105,164,480,000)	(115,023,996,000)	(116,473,008,000)	(119,944,908,000)	(+14,780,428,000)	(+4,920,912,000)	(+3,471,900,000)
1992 advance.....	(17,346,488,000)	(19,453,000,000)	(19,453,000,000)	(21,614,034,000)	(+4,267,546,000)	(+2,161,034,000)	(+2,161,034,000)
Unauthorized, not considered by House.....	(4,709,923,000)	(4,333,989,000)	DEFER	(5,389,055,000)	(+679,132,000)	(+1,055,066,000)	(+5,389,055,000)
Total, authorized and unauthorized.....	(127,220,891,000)	(138,810,985,000)	DEFER	(146,947,997,000)	(+19,727,106,000)	(+8,137,012,000)	(+11,021,989,000)
Trust Funds.....	(5,767,111,000)	(6,088,805,000)	(6,279,322,000)	(6,244,572,000)	(+477,461,000)	(+155,767,000)	(-34,750,000)
Title III - Department of Education:							
Federal Funds.....	23,012,014,000	23,549,441,000	26,082,051,000	26,463,391,000	+3,451,377,000	+2,913,950,000	+381,340,000
Unauthorized, not considered by House.....	(1,118,461,000)	(1,111,540,000)	DEFER	(1,213,008,000)	(+94,547,000)	(+101,468,000)	(+1,213,008,000)
Total, authorized and unauthorized.....	(24,130,475,000)	(24,660,981,000)	DEFER	(27,676,399,000)	(+3,546,924,000)	(+3,015,418,000)	(+1,594,348,000)

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	House Bill	Senate Recommendation	FY 1990	Senate compared with FY 1991 Budget	House Bill
PRIORITY DISEASE CONTROL AND RESEARCH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) (HON-AID)							
Health Resources and Services Administration:							
Training of health personnel.....	(14,549,000)	(21,000,000)	(17,500,000)	(17,500,000)	(+2,951,000)	(-3,500,000)	---
Facilities renovation grants (1610 (b)).....	(4,342,000)	(4,129,000)	(4,129,000)	---	(-4,342,000)	(-4,129,000)	(-4,129,000)
Pediatric health care demonstrations.....	(14,803,000)	(14,803,000)	(20,000,000)	---	(-14,803,000)	(-14,803,000)	(-20,000,000)
Adult health care demonstrations.....	(17,209,000)	(19,424,000)	(27,200,000)	---	(-17,209,000)	(-19,424,000)	(-27,200,000)
AIDS-related drugs.....	(29,606,000)	---	---	---	(-29,606,000)	---	---
Community health care services.....	(10,777,000)	(13,323,000)	(13,323,000)	---	(-10,777,000)	(-13,323,000)	(-13,323,000)
Home health services.....	(19,737,000)	---	---	---	(-19,737,000)	---	---
Subacute care.....	(1,480,000)	---	---	---	(-1,480,000)	---	---
Emergency assistance:							
1991.....	---	---	---	(49,000,000)	(+49,000,000)	(+49,000,000)	(+49,000,000)
1992 1/.....	---	---	---	(251,000,000)	(+251,000,000)	(+251,000,000)	(+251,000,000)
Transfer for consolidated administration.....	(-4,786,000)	(-4,786,000)	(-4,786,000)	---	(+4,786,000)	(+4,786,000)	(+4,786,000)
Comprehensive care programs							
1991.....	---	---	---	(110,000,000)	(+110,000,000)	(+110,000,000)	(+110,000,000)
1992 2/.....	---	---	---	(190,000,000)	(+190,000,000)	(+190,000,000)	(+190,000,000)
Subtotal, HRSA.....	(107,717,000)	(67,893,000)	(77,366,000)	(617,500,000)	(+509,783,000)	(+549,607,000)	(+540,134,000)
Centers for Disease Control:							
Epidemiology/surveillance.....	(127,325,000)	(146,560,000)	(146,560,000)	(146,560,000)	(+19,235,000)	---	---
Information/education.....	(195,830,000)	(232,502,000)	(232,502,000)	(232,502,000)	(+36,672,000)	---	---
Testing/counseling.....	(119,402,000)	(130,041,000)	(130,041,000)	(130,041,000)	(+10,639,000)	---	---
Other.....	(6,915,000)	---	---	---	(-6,915,000)	---	---
Subtotal, CDC.....	(449,472,000)	(509,103,000)	(509,103,000)	(509,103,000)	(+59,631,000)	---	---

1/ Available for obligation October 1, 1991.

2/ \$190,000,000 not available for obligation until October 1, 1991.

MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH
AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1991, AND FOR OTHER
PURPOSES

OCTOBER 20, 1990.—Ordered to be printed

Mr. NATCHER, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 5257]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 5257) making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies, for the fiscal year ending Sept. 30, 1991, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 6, 13, 22, 28, 33, 64, 70, 75, 90, 92, 93, 104, 105, 106, 107-108, 123, 132, 137, 143, 151, 154, 157, 158, 159, 160, 161, 167, 172, 175, 178, and 185.

That the House recede from its disagreement to the amendments of the Senate numbered 1, 2, 11, 23, 30, 66, 67, 72, 74, 85, 86, 94, 109, 115, 126, 127, 128, 129, 134, 140, 141, 145, 148, 149, 153, 165, 166, 174, 180, and 182, and agree to the same.

Amendment numbered 3:

That the House recede from its disagreement to the amendment of the Senate numbered 3, and agree to the same with an amendment, as follows:

In lieu of the sum proposed by said amendment insert \$4,098,236,000; and the Senate agree to the same.

Amendment numbered 4:

That the House recede from its disagreement to the amendment of the Senate numbered 4, and agree to the same with an amendment, as follows:

In lieu of the sum proposed by said amendment insert \$61,097,000; and the Senate agree to the same.

Amendment numbered 5:

VIN WEBER,
Managers on the Part of the House.

TOM HARKIN,
 ROBERT C. BYRD,
 ERNEST F. HOLLINGS,
 QUENTIN N. BURDICK,
 DANIEL K. INOUE,
 DALE BUMPERS,
 HARRY REID,
 BROCK ADAMS,
 ARLEN SPECTER,
 MARK O. HATFIELD,
 WARREN B. RUDMAN,
 JAMES A. MCCLURE,
 THAD COCHRAN,
 PHIL GRAMM,

Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and Senate at the conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 5257) making appropriations for the Departments of Labor, Health and Human Services, and Education, and Related Agencies, for the fiscal year ending September 30, 1991, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report.

TITLE I—DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

PROGRAM ADMINISTRATION

Amendment No. 1: Appropriates \$71,480,000 as proposed by the Senate instead of \$70,030,000 as proposed by the House.

The conferees include funding for the School-to-Work demonstration programs begun in fiscal year 1990. The conferees encourage the Secretary to transfer funds made available under Title IV for pilot and demonstration programs to ensure adequate support to continue and expand this vital initiative.

Amendment No. 2: Makes available \$54,301,000 from the Unemployment Trust Fund as proposed by the Senate instead of \$54,751,000 as proposed by the House.

TRAINING AND EMPLOYMENT SERVICES

Amendment No. 3: Appropriates \$4,098,236,000 instead of \$4,136,447,000 as proposed by the House and \$4,035,188,000 as proposed by the Senate.

The conference agreement includes \$4,199,000 for labor market information and \$5,390,000 for training and technical assistance. The agreement also includes \$3,500,000 to continue the Samoan

and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert:
\$135,359,000

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

TITLE II—DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

PROGRAM OPERATIONS

Amendment No. 25: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate which adds legal citations for programs not considered by the House.

Amendment No. 26: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert:
\$2,139,382,000

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

The conferees intend that a portion of the increase provided for community health centers above the President's request be used to establish new centers. The conferees urge the Department to give priority to areas that have inadequate services for low income populations, primary care physician shortages, poverty rates of at least 25 percent, and concentrations of minority populations.

The conference agreement provides \$20,000,000 for health services outreach grants, as described in the Senate report. The conferees expect that at least 85 percent of each grant shall be used to support outreach and care services through health and mental health care consortia. The conferees intend outreach grants to enable services to be provided to rural populations that are not receiving them. The grants should be used by coalitions of existing providers (such as hospitals, health departments, community or migrant health centers, Rural Health Clinics, private practitioners, or other publicly funded health or social service agencies) to enhance service capacity or expand service area, thus increasing the number of individuals and families receiving services.

The conferees intend that HRSA shall manage this program through the Office of the Administrator, and encourage the Administrator to employ the expertise of the Office of Rural Health Policy and HRSA bureaus for optimum direction of this program.

The conferees urge the Administrator to award a portion of the funds provided for services outreach grants to applications that involve the delivery of comprehensive services to rural elderly (including hearing, vision and dental services) through a consortium including private practitioners, the appropriate health professions schools, and a health department, as well as a research and public policy component, in a State with a large percentage of elderly in-

dividuals. The conferees also express interest in applications that involve the delivery of maternal health care through consortia of public health, public welfare, and social services agencies and hospital systems.

The conferees believe that the nation must make a greater commitment to improving the health status of minorities in the United States and increasing their representation in the health professions. The conferees express their strong support for the initiatives created by the Disadvantaged Minority Health Improvement Act of 1990 and have provided \$20,000,000 as initial start-up funding for these new programs. The conferees intend that the funds provided be allocated as follows:

Hispanic Centers	\$1,500,000
Native American Centers	1,000,000
Grants for Scholarships.....	8,500,000
Federal Capital Contributions to Student Loan Funds.....	3,000,000
Loan Repayment for Faculty Service.....	1,000,000
Grants to States/Community-Based Organizations for Scholarships.....	500,000
Health Services for Residents of Public Housing.....	3,500,000
Data Collection	1,000,000

The conferees intend that the data collection funds be administered by the National Center for Health Statistics within the Centers for Disease Control and would expect the funds to be transferred to CDC through a cooperative agreement. The conferees also expect the Secretary to consider the needs of Native Hawaiians and Alaskan Natives in implementing the Act.

The conferees expect that no grantee receiving funds from the Health Care for the Homeless program will be phased out or directed to operate at a reduced level for budgetary reasons based on the conferees' decision to implement a fiscal year funding cycle.

The conferees are concerned about the shortages of physicians and other health care professionals in some urban and rural areas and have provided a significant increase in funding for National Health Service Corps scholarships and loan repayments to address these shortages. The conferees are also concerned, however, about the impact of this funding increase on outyear program costs and believe that outyear costs should be taken into consideration when decisions are made about the design of the expanded scholarship and loan program.

The conference agreement includes \$4,500,000 for interdisciplinary training. Of this amount, \$4,000,000 is provided for interdisciplinary training grants. The additional \$500,000 is provided for a grant to extend and expand the existing Bureau of Health Professions study of integrated education and service models for rural health care professionals.

The conference agreement provides \$3,500,000 for Native Hawaiian health care. Of this amount, \$2,350,000 is for Native Hawaiian health centers, \$750,000 is for the scholarship program administered by Kamehameha Schools/Bishop Estate, and \$400,000 is for administrative costs of Papa Ola Lokahi.

The conferees intend that the \$1,491,000 provided for the nurse loan repayment to shortage-area service program be used in roughly equal proportions for the programs authorized under section 836(h) and section 847 of the Public Health Service Act. The conferees request that the Department report to the Committees during

the fiscal year 1992 hearing cycle concerning the relative capacity of these two programs to use funding.

Within the total of \$3,857,000 provided for organ transplantation, the conferees have provided \$600,000 to be made available to the Division of Organ Transplantation to make grants to, and enter contracts with, qualified organ procurement organizations, described in section 371 of the Public Health Service Act, and other nonprofit private entities for the purpose of carrying out special projects to increase the supply of donated organs. Programs may include new education and training demonstration programs to enhance the ability of organ procurement organizations or other entities to focus limited resources, and to develop and implement systematic management and monitoring systems to increase the availability of donated organs. With the limited funding available from the Federal sector, it is important that the Division encourage private matching funds for a public/private partnership to help solve the organ shortage. Grantees should work in concert with the national required referral program mandated by section 1138(a)(1)(A) of the Social Security Act.

The conferees intend that funds used to administer the AIDS programs within the Health Resources and Services Administration be derived only from the Program Management line item rather than from a tap against AIDS program funds.

The conferees understand that a recent surge in vaccine injury compensation applications may increase the administrative costs of the program beyond anticipated levels. The conferees agree that the Department, if it chooses, may use program management funds of the Health Resources and Services Administration to supplement the funds made available from the Vaccine Injury Compensation Trust Fund for administrative costs.

Amendment No. 27: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment, insert: , of which \$4,129,000 shall be made available until expended to make grants under section 1610(b) of the Public Health Service Act for renovation or construction of nonacute care intermediate and long-term care facilities for AIDS patients, of which \$1,000,000 shall be available until expended under section 1610(b) of the Public Health Service Act to make grants to be awarded competitively for the renovation or construction of tertiary perinatal facilities in those States whose infant mortality rate is significantly above the national average, and of which \$226,000,000 shall be available for title XXVI of the Public Health Service Act: Provided, That the Secretary shall retain and distribute from the total provided for title XXVI of the Act such amounts as may be necessary to ensure the continuation of health care services through September 30, 1991 provided by grantees whose project periods extend through that date.

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

The conferees have provided a total of \$267,629,000 for AIDS activities within the Health Resources and Services Administration.

Of this amount, \$41,629,000 is provided to continue ongoing training activities, facility renovation grants, and pediatric AIDS demonstrations. \$226,000,000 in fiscal year 1991 funding is provided for the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 as follows:

Title I: \$90,000,000.

Title II: 90,000,000.

Title III: 46,000,000.

No advance funding is provided for fiscal year 1992. In addition, \$130,000,000 of funding for the AIDS program at the Centers for Disease Control supports the purpose of title III of the Ryan White Act, for a total of \$356,000,000 for Ryan White programs.

The conferees recognize that it may require several months to implement the new programs authorized under the Ryan White Act and do not intend that any disruption in services occur as current programs are melded into the new Ryan White activities. As a result, the conferees have included bill language directing the Secretary to retain such funds as he considers necessary from the amounts provided for the Ryan White Act to continue services through grantees who would otherwise have received funding in fiscal year 1991. The conferees encourage the Secretary to support current grantees during this transition period under the terms and conditions described in the House report, especially as they relate to mental health services.

The conferees intend that the majority of funds provided for Title III of the Ryan White Act be used for categorical grants authorized under section 2651 of the Act. If, however, in the judgment of the Secretary, it is appropriate to use a portion of the funds provided for Title III for activities authorized under section 2641 of the Act pertaining to State grants, the conferees intend that these resources be transferred from HRSA to the Centers for Disease Control under a cooperative agreement.

The conferees direct the Secretary to set aside \$3,000,000 of the funds provided under Title II of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 for special projects of national significance to compensate dental schools and postdoctoral dental education programs for the costs they have incurred in providing oral health services to AIDS patients. Eligibility for these funds and administration of this program is to be as authorized in section 788A(f) of the Public Health Service Act. The conferees also urge the Secretary to consider using funds for special projects of national significance to provide grants to HIV/AIDS Projects in those jurisdictions which can demonstrate over 2,000 cases of AIDS diagnosed as of June 30, 1990 and subsequently reported to the Centers for Disease Control by October 31, 1990 and which serve a high percentage of minority, low-income and IV drug user AIDS populations.

The conference agreement includes \$1,000,000 for competitive grants for the renovation or construction of tertiary perinatal facilities in States whose mortality rate is significantly above the national average.

Amendment No. 28: Restores language proposed by the House which establishes a limit on obligatory authority for Health Education and Assistance Loans.

AGENCY FOR HEALTH CARE POLICY AND RESEARCH

HEALTH CARE POLICY AND RESEARCH

Amendment No. 63: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert:
\$98,887,000

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

Amendment No. 64: Places a limitation of \$13,776,000 on amounts available pursuant to section 926(b) of the Public Health Service Act as proposed by the House instead of \$40,776,000 as proposed by the Senate.

HEALTH CARE FINANCING ADMINISTRATION

GRANTS TO STATES FOR MEDICAID

Amendment No. 65: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert:
\$36,966,394,000

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

Amendment No. 66: Appropriates \$13,500,000,000 for advance funding for the first quarter of fiscal year 1992 as proposed by the Senate instead of \$12,400,000,000 as proposed by the House.

PAYMENTS TO HEALTH CARE TRUST FUNDS

Amendment No. 67: Appropriates \$35,335,000,000 as proposed by the Senate instead of \$37,056,000,000 as proposed by the House.

PROGRAM MANAGEMENT

Amendment No. 68: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert:
\$105,466,000

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

Amendment No. 69: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert:
\$2,029,138,000

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

Amendment No. 70: Deletes language proposed by the Senate which would have established a system of user fees for Medicare and Medicaid survey and certification activities.

SOCIAL SECURITY ADMINISTRATION

SUPPLEMENTAL SECURITY INCOME PROGRAM

Amendment No. 71: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert:
\$14,031,394,000

The managers on the part of the Senate will move to concur in the amendment to the House to the amendment of the Senate.

The conferees have deleted \$1,000,000 for an outreach and education program on Medicare Supplemental policies. The conferees understand that a comprehensive Medigap consumer education project will be authorized in the budget reconciliation legislation and funded out of the Social Security Trust Funds.

LIMITATION ON ADMINISTRATIVE EXPENSES

Amendment No. 72: Provides for a limitation on trust funds of \$4,316,974,000 as proposed by the Senate instead of \$4,166,974,000 as proposed by the House.

Amendment No. 73: Provides a contingency reserve of \$150,000,000 instead of \$50,000,000 as proposed by the House and \$200,000,000 as proposed by the Senate.

As in previous years, the conference agreement includes a contingency reserve for workloads not anticipated in the budget estimates.

FAMILY SUPPORT ADMINISTRATION

FAMILY SUPPORT PAYMENTS TO STATES

Amendment No. 74: Appropriates \$10,172,346,000 as proposed by the Senate instead of \$9,657,246,000 as proposed by the House.

PAYMENTS TO STATES FOR AFDC WORK PROGRAMS

Amendment No. 75: Appropriates \$1,000,000,000 as proposed by the House instead of \$1,006,500,000 as proposed by the Senate and deletes language proposed by the Senate which provided \$6,500,000 for job creation demonstration projects authorized under section 505 of the Family Support Act. The conferees have provided \$4,500,000 for these demonstrations in the Program Administration account under amendment numbered 81.

LOW INCOME HOME ENERGY ASSISTANCE

Amendment No. 76: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate which appropriates \$1,450,000,000 for the program.

The conferees are agreed that the recent volatility of energy prices poses economic hardship for low income families.

ENERGY EMERGENCY CONTINGENCY FUND

Amendment No. 77: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the matter inserted by said amendment, insert:

ENERGY EMERGENCY CONTINGENCY FUND

For the purpose of establishing an "Energy Emergency Contingency Fund," in the United States Treasury to be available for grants to the fifty States, the District of Columbia, and Indian tribes and tribal organizations receiving direct funding in fiscal year 1991 under the Low-Income Home Energy Assistance Act of 1981, \$200,000,000 which shall be available for obligation after January 15, 1991: Provided, That the national average retail price of home heating oil in any of the months December 1990, January 1991, or February 1991, as reported for Petroleum Marketing Monthly by the Energy Information Administration or the best available data from the Department of Energy on the last day of the month following such month, exceeds by 20 per centum or more the average of the national average retail price for home heating oil for the corresponding month as reported by the Department of Energy for 1986, 1987, 1988, and 1989: Provided further, That these funds shall be allotted to the fifty States and the District of Columbia in proportion to the consumption by low-income households in such jurisdiction (determined on the basis of the best data available at the time of allotment) of home heating oil: Provided further, That for allotment purposes only, home heating oil includes liquified petroleum gas and kerosene: Provided further, That Indian tribes and tribal organizations shall receive the same per centum of the allotment of the State or States in which they are located as they receive from that State's (or those States') allotment for fiscal year 1991 under section 2604 of the Low-Income Home Energy Assistance Act.

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

REFUGEE AND ENTRANT ASSISTANCE

Amendment No. 78: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the matter inserted by said amendment, insert:

REFUGEE AND ENTRANT ASSISTANCE

For making payments for refugee and entrant assistance activities authorized by title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96-422), \$420,770,000, of which \$240,000,000 shall be available for State cash and medical assistance.

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

The conference agreement for targeted assistance includes the same funding level as provided in fiscal year 1990 to continue the current program of support to communities affected as a result of the massive influx of Cuban and Haitian entrants during the Mariel boatlift. The conference agreement also provides that 10 percent of the total amount appropriated for targeted assistance be used for grants to localities most heavily impacted by the influx of refugees such as Laotian Hmong, Cambodians, and Soviet Pentecostals, including secondary migrants who entered the United States after October 1, 1979. The conferees expect these grants to be awarded to communities not presently receiving targeted assistance because of previous concentration requirements and other factors in the grant formulas, as well as those who do currently receive targeted assistance grants. This agreement is consistent with the policy established in Public Law 101-166, the fiscal year 1990 Appropriations Act, and Public Law 101-302, the fiscal year 1990 Supplemental Appropriations Act.

The conferees intend that the State of California, which has 49 percent of the nation's refugees and is the most impacted state in the nation, shall be held harmless in the formula allocation of targeted assistance funds as a result of any reductions to the total amount appropriated for the targeted assistance program. California's total share of funding under the formula allocation in fiscal year 1991 should be no less than the percentage share of California's allotment under fiscal year 1990 appropriations, excluding funds appropriated by Public Law 101-302, the fiscal year 1990 Supplemental Appropriations Act. In determining the hold harmless allocation to California, the total amount appropriated for targeted assistance will be used.

The conferees are agreed that not more than 15 percent of funding appropriated for social services may be used for discretionary grants.

INTERIM ASSISTANCE TO STATES FOR LEGALIZATION

Amendments No. 79: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the matter inserted by said amendment, insert:

INTERIM ASSISTANCE TO STATES FOR LEGALIZATION

Section 204(a)(1)(B) of the Immigration Reform and Control Act of 1986 is amended—

(1) by striking the period at the end thereof and inserting in its place the following: ", and funds appropriated for fiscal year 1991 under this section are reduced by \$566,854,000."

Section 204(a)(1)(C) of the Immigration Reform and Control Act of 1986 is amended—

(1) by striking "\$1,000,000,000" and inserting in its place "\$2,000,000,000"; and

(2) by inserting "for each of fiscal years 1990 and 1991" after "paragraph (2)", and

(3) by striking the period at the end thereof and inserting in its place the following: "and fiscal year 1991."

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

The conferees have agreed to shift appropriations from fiscal year 1991 to 1992 in order to more closely reflect projected outlay patterns. The conferees believe that the remaining appropriation for fiscal year 1991, when combined with the unspent appropriations from fiscal years 1988, 1989 and 1990, will be sufficient to meet the needs of State and local governments and legalized aliens in fiscal year 1991. The funds appropriated for fiscal year 1992 are made available under the same terms and conditions as they would have been in 1991. The conferees have deleted language proposed by the Senate which would have amended the authorization.

The conferees direct the Secretary to allow states to use State Legalization Impact Assistance Grant (SLIAG) funds to reimburse state or local costs of medical assistance provided to eligible legalized aliens which are not otherwise reimbursed or paid by the Federal government, the alien, or other private sources, consistent with the intent of the Immigration Reform and Control Act of 1986. The conferees understand that the Department currently requires states to deduct any amount owed by legalized aliens to public hospitals in determining the amount of medical costs that can be reimbursed by SLIAG funds even if the amount is never paid by the aliens. The conferees direct that only the portion of costs actually paid by the aliens be deducted in computing the amount of costs that can be reimbursed by SLIAG funds. The conferees further direct that the Secretary implement this policy as soon as possible to expedite the reimbursement of state and local costs of medical care provided to legalized aliens. The conferees agree that this directive should only be followed if authorized by law.

COMMUNITY SERVICES BLOCK GRANT

Amendment No. 80: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the first sum proposed in said amendment, insert:
\$438,300,000

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

PROGRAM ADMINISTRATION

Amendment No. 81: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert:
\$86,450,000

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

The conference agreement includes \$2,000,000 for child access demonstration projects and \$4,500,000 for job creation demonstration projects authorized under section 505 of the Family Support Act of 1988. The job creation demonstration projects are administered by the Office of Community Services. The conferees note that the fiscal year 1990 funding for this demonstration did not provide for any grants to Community Development Corporations. The conferees expect FSA to make a special effort to ensure that these organizations participate in this program in fiscal year 1991.

ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

HUMAN DEVELOPMENT SERVICES

Amendment No. 82: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate which inserts legal citations.

Amendment No. 83: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert:
\$3,519,699,000

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

The conference agreement includes \$3,000,000 for the elder abuse prevention program and \$2,500,000 for the long-term care ombudsman program. The conferees intend that these funds be used to supplement and not replace existing support for these programs. It is the expectation of the conferees that the States be given discretion in the allocation of the elder abuse funds so as to provide for the most effective elder abuse prevention efforts. It is further the conferees' expectation that portions of the elder abuse funds will be made available to State long-term care ombudsman programs to address complaints of abuse in long-term care facilities, including board and care homes.

The conferees have included \$2,500,000 in the Head Start research, demonstration, and evaluation function to initiate a 3-year project to demonstrate the effectiveness of training Head Start teachers through interactive education via satellite technology. The project shall be managed by a public television station with substantial experience in early childhood education teacher training and staff development programming, in partnership with other public television stations and the early childhood educational professional community. To the greatest extent possible, equipment and facilities provided previously by Federal funds shall be utilized.

In the Administration for Native Americans, the conferees have included \$1,000,000 to fund the planning proposal for the establishment of a national center for Native American studies and policy development, as authorized by P.L. 101-301, and \$1,000,000 to provide assistance to groups that are severely impacted by natural or man-made disasters, such as large oil spills.

Amendment No. 84: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the matter inserted by said amendment, insert:

For carrying out the Child Care and Development Block Grant Act of 1990, \$750,000,000 which shall become available for obligation on September 7, 1991: Provided, That these funds shall only become available upon enactment into law of authorizing legislation.

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE

(INCLUDING TRANSFER OF FUNDS)

Amendment No. 85: Appropriates \$2,611,281,000 as proposed by the Senate instead of \$2,632,192,000 as proposed by the House.

Amendment No. 86: Earmarks \$520,911,000 for payment of prior years' claims as proposed by the Senate instead of \$544,000,000 as proposed by the House.

Amendment No. 87: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment, as follows:

In lieu of the matter inserted by said amendment, insert: Provided, That of the total amount provided, \$27,352,000 shall be transferred to the "Human Development Services" account for part B of title IV of the Act

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

OFFICE OF THE SECRETARY

GENERAL DEPARTMENTAL MANAGEMENT

Amendment No. 88: Appropriates \$81,350,000 instead of \$82,250,000 as proposed by the House and \$75,500,000 as proposed by the Senate.

Amendment No. 89: Makes available \$31,100,000 from the Social Security trust funds instead of \$31,950,000 as proposed by the House and \$28,950,000 as proposed by the Senate.

The conference agreement includes both the rural transportation technical assistance program and the transportation technical assistance program related to the Americans with Disabilities Act.

POLICY RESEARCH

Amendment No. 90: Appropriates \$9,167,000 as proposed by the House instead of \$8,167,000 as proposed by the Senate.

Amendment No. 91: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate which provides that certain research on poverty be conducted by the Institute for Research on Poverty.

Amendment No. 92: Deletes language proposed by the Senate.

CONFERENCE AGREEMENT: H.R. 5357 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

SUMMARY

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final	Conference Final vs Senate Bill	Final Dis
Title I - Department of Labor:								
Federal Funds.....	6,599,016,000	7,210,325,000	7,648,593,000	7,582,271,000	7,646,083,000	7,505,314,000	-143,279,000	-76,957,000
Current year.....	(6,597,516,000)	(7,210,325,000)	(7,648,593,000)	(7,582,271,000)	(7,646,083,000)	(7,505,314,000)	-143,279,000	(-76,957,000)
1992 advance.....	(1,500,000)	---	---	---	---	---	---	---
Activities not considered by House.....	(11,343,000)	(11,500,000)	BEFER	(11,500,000)	(11,500,000)	(11,223,000)	(-11,223,000)	(-277,000)
Total.....	(6,610,359,000)	(7,229,825,000)	(7,648,593,000)	(7,593,771,000)	(7,657,583,000)	(7,516,537,000)	(-132,056,000)	(-77,234,000)
Trust Funds.....	(2,941,886,000)	(3,107,139,000)	(3,156,566,000)	(3,171,212,000)	(3,249,862,000)	(3,171,639,000)	(-15,073,000)	(-427,000)
1991 advance.....	(12,500,000)	---	---	---	---	---	---	---
Activities not considered by House.....	(24,653,000)	---	BEFER	(20,000,000)	(20,000,000)	(19,518,000)	(-19,518,000)	(-482,000)
Title II - Department of Health and Human Services:								
Federal Funds (all years).....	122,503,081,000	136,175,978,000	135,916,006,000	139,760,731,000	140,352,392,000	139,925,555,000	+4,009,547,000	+164,824,000
Current year.....	(105,156,593,000)	(117,278,222,000)	(116,463,006,000)	(118,628,697,000)	(119,220,358,000)	(118,807,476,000)	(-2,344,468,000)	(-178,779,000)
1992 advance.....	(17,346,488,000)	(18,897,756,000)	(19,453,000,000)	(21,132,034,000)	(21,132,034,000)	(21,110,079,000)	(-1,665,079,000)	(-13,955,000)
Activities not considered by House.....	(6,717,810,000)	(4,338,915,000)	BEFER	(7,187,264,000)	(6,389,381,000)	(6,235,400,000)	(-6,235,400,000)	(-951,866,000)
Total.....	(127,220,891,000)	(140,514,893,000)	(135,926,006,000)	(146,947,997,000)	(146,741,773,000)	(146,160,955,000)	(-10,234,947,000)	(-787,042,000)
Trust Funds.....	(5,767,111,000)	(6,088,805,000)	(6,279,322,000)	(6,244,572,000)	(6,373,872,000)	(6,218,987,000)	(-60,335,000)	(-25,585,000)
Title III - Department of Education:								
Federal Funds.....	23,600,814,000	24,931,794,000	26,082,051,000	26,459,139,000	26,899,326,000	26,206,977,000	+74,926,000	-252,162,000
Activities not considered by House.....	(1,123,406,000)	(1,111,540,000)	BEFER	(1,218,008,000)	(1,249,422,000)	(1,219,315,000)	(-1,219,315,000)	(-1,307,000)
Total.....	(24,724,220,000)	(26,043,334,000)	(26,082,051,000)	(27,677,147,000)	(27,948,748,000)	(27,426,292,000)	(-1,341,000)	(-250,855,000)

CONFERENCE AGREEMENT: H. R. 5257 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

TITLE I -- DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

PROGRAM ADMINISTRATION

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final -2 dls	Conference Final vs House Bill	Conference Final vs Senate Bill	Disc
Job training programs.....	18,540,000	19,834,000	19,834,000	19,834,000	19,834,000	19,356,000	-478,000	-478,000	D
Trust funds.....	(2,057,000)	(2,170,000)	(2,170,000)	(2,170,000)	(2,170,000)	(2,118,000)	(-52,000)	(-52,000)	TF
Employment security.....	442,000	464,000	464,000	464,000	464,000	453,000	-11,000	-11,000	D
Trust funds.....	(13,032,000)	(13,406,000)	(13,406,000)	(13,406,000)	(13,406,000)	(13,083,000)	(-323,000)	(-323,000)	TF
Financial and administrative management.....	14,056,000	14,330,000	14,880,000	14,330,000	14,330,000	13,985,000	-895,000	-895,000	D
Trust funds.....	(10,544,000)	(10,586,000)	(11,036,000)	(10,586,000)	(10,586,000)	(10,331,000)	(-705,000)	(-255,000)	TF
Executive direction and administration.....	3,806,000	4,283,000	4,283,000	4,283,000	4,283,000	4,180,000	-103,000	-103,000	D
Trust funds.....	(3,097,000)	(3,360,000)	(3,360,000)	(3,360,000)	(3,360,000)	(3,279,000)	(-81,000)	(-81,000)	TF
Regional operations.....	12,268,000	12,942,000	15,942,000	15,942,000	15,942,000	15,577,000	365,000	365,000	D
Trust funds.....	(24,384,000)	(24,779,000)	(24,779,000)	(24,779,000)	(24,779,000)	(24,182,000)	597,000	597,000	TF
Apprenticeship services.....	15,517,000	14,607,000	14,607,000	16,607,000	16,607,000	16,207,000	400,000	400,000	D
Total, Program Administration.....	117,743,000	120,781,000	124,781,000	125,781,000	125,781,000	122,751,000	-2,030,000	-3,030,000	
Federal funds.....	64,629,000	66,480,000	70,030,000	71,480,000	71,480,000	69,758,000	-272,000	-1,732,000	
Trust funds.....	(53,114,000)	(54,301,000)	(54,751,000)	(54,301,000)	(54,301,000)	(52,993,000)	(-1,738,000)	(-1,308,000)	

CONFERENCE AGREEMENT: H.R. 5357 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

TITLE 11--DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

HEALTH RESOURCES AND SERVICES

Health Care Delivery and Assistance:

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final -2,418	Conference Final as House Bill	Hand Senate Hill Diac
Community health centers.....	456,914,000	471,785,000	490,000,000	477,000,000	490,000,000	478,191,000	-11,809,000	+1,191,000 D
Health services outreach grants.....	---	---	---	20,000,000	20,000,000	19,518,000	-482,000	-482,000 D
Minority initiatives.....	---	(39,000,000)	DEFER	---	(20,000,000)	(19,518,000)	(-19,518,000)	(-19,518,000) D
Total, Community Health Services.....	456,914,000	504,785,000	490,000,000	497,000,000	530,000,000	517,227,000	+27,227,000	+20,227,000
Migrant health.....	49,343,000	50,601,000	52,000,000	54,000,000	53,000,000	51,723,000	-277,000	-2,277,000 D
Black lung clinics.....	3,651,000	3,651,000	3,600,000	3,800,000	3,800,000	3,708,000	-92,000	-92,000 D
Health care for the homeless.....	35,967,000	33,667,000	40,000,000	40,000,000	40,000,000	39,036,000	-964,000	-964,000 D
Advance funding for FY 1991.....	11,885,000	---	---	---	---	---	---	---
Family planning I/.....	(139,135,000)	(139,135,000)	DEFER	(148,000,000)	(148,000,000)	(144,433,000)	(-3,567,000)	(-3,567,000) D
National Health Service Corps: Field placements.....	(39,337,000)	(42,361,000)	DEFER	(44,000,000)	(44,000,000)	(42,940,000)	(-1,060,000)	(-1,060,000) D
Loans and scholarships.....	(11,382,000)	(63,882,000)	DEFER	(63,882,000)	(50,000,000)	(48,795,000)	(-1,087,000)	(-1,087,000) D
Subtotal, Natl Health Service Corps.....	(50,719,000)	(104,243,000)	DEFER	(107,882,000)	(94,000,000)	(91,735,000)	(-2,147,000)	(-2,147,000) D
Nurse's Disease services (Cervile).....	(18,138,000)	(22,601,000)	(20,401,000)	(20,401,000)	(20,401,000)	(20,105,000)	(-296,000)	(-296,000) D
Payment to Hawaii, treatment of Hansen's Disease..	3,217,000	3,217,000	3,300,000	3,467,000	3,467,000	3,383,000	-84,000	-84,000 D
Hose health demonstration grants.....	(2,961,000)	---	DEFER	(3,211,000)	(3,000,000)	(2,928,000)	(-73,000)	(-73,000) D
Total, Health Care Delivery & Assistance.....	771,950,000	865,900,000	609,701,000	677,561,000	895,668,000	874,278,000	+21,388,000	+3,463,000

1/ President's FY 1991 Budget requests Family Planning under "Public Health Service Management" account.

CONFERENCE AGREEMENT: H.R. 9237 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comptroller	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final - 2 dia	Conference House Bill	Conference Final vs Senate Bill	End Dian
Acquired Immune Deficiency Syndrome (AIDS):									
Training of health personnel.....	14,549,000	21,000,000	17,500,000	17,500,000	17,500,000	17,076,000	122,000	-422,000	0
Facilities renovation grants.....	4,342,000	4,129,000	4,129,000	---	4,129,000	4,039,000	100,000	+4,039,000	0
Pediatric health care demonstrations.....	14,803,000	14,803,000	20,000,000	---	20,000,000	19,518,000	-482,000	+19,518,000	0
Adult health care demonstrations.....	17,209,000	19,424,000	27,200,000	---	---	---	-27,200,000	---	0
AIDS related drugs (ART).....	(29,606,000)	---	DEFER	---	---	---	---	---	0
Community health care services.....	10,777,000	13,323,000	13,323,000	---	---	---	-13,323,000	---	0
Home health services.....	19,737,000	---	---	---	---	---	---	---	0
Subacute care.....	1,480,000	---	---	---	---	---	---	---	0
Transfer for consolidated administration.....	-4,786,000	-4,786,000	-4,786,000	---	---	---	+4,786,000	---	0
Ryan White AIDS Program:									
Emergency assistance:									
1991.....	---	---	---	(49,000,000)	(90,000,000)	(87,831,000)	(+87,831,000)	(-18,831,000)	0
1992.....	---	---	---	(251,000,000)	---	---	---	(-251,000,000)	0
Comprehensive care programs:									
1991.....	---	---	---	(110,000,000)	(90,000,000)	(87,831,000)	(+87,831,000)	(-22,169,000)	0
1992.....	---	---	---	(190,000,000)	---	---	---	(-190,000,000)	0
Early intervention programs.....	---	---	---	---	(46,000,000)	(44,891,000)	(+44,891,000)	(-44,891,000)	0
Subtotal, Ryan White AIDS programs.....	---	---	---	600,000,000	226,000,000	220,533,000	-220,533,000	-379,447,000	
Program management including AIDS.....									
Subtotal, AIDS.....	107,717,000	87,693,000	77,366,000	617,500,000	267,629,000	261,176,000	-189,812,000	-356,322,000	
Subtotal, Health resources and services.....	99,170,000	99,551,000	102,000,000	104,551,000	103,276,000	100,787,000	-1,213,000	-3,764,000	0
Total, Health resources and services.....	1,539,387,000	1,596,579,000	1,627,375,000	1,615,947,000	1,640,392,000	1,606,639,000	-18,717,000	-7,189,000	
Acquisition not considered by House.....	(222,421,000)	(287,378,000)	DEFER	(859,093,000)	(491,000,000)	(479,167,000)	(+479,167,000)	(-379,926,000)	
Total.....	(1,760,808,000)	(1,695,937,000)	(1,627,375,000)	(2,474,940,000)	(2,139,392,000)	(2,087,825,000)	(+480,450,000)	(-387,115,000)	

CONFERENCE AGREEMENT: H.R. 5257 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

HEALTH CARE FINANCING ADMINISTRATION
GRANTS TO STATES FOR MEDICAID 1/

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final -2.4%	Conference Final vs House Bill	House Bill	Senate Bill	Hard Dis
Medicaid current law benefits.....	38,214,759,000	45,219,954,000	42,868,326,000	45,219,954,000	45,219,954,000	45,219,954,000	+2,351,428,000	---	---	M
State and local administration.....	2,014,743,000	2,349,686,000	2,166,440,000	2,166,440,000	2,166,440,000	2,166,440,000	---	---	---	M
Proposed legislation, user fees.....	---	-119,457,000	---	-85,093,000	---	---	---	---	+85,093,000	D
Subtotal, Medicaid program level, FY 1991.....	40,229,502,000	47,456,183,000	45,034,766,000	47,281,301,000	47,386,394,000	47,386,394,000	+2,351,428,000	---	+85,093,000	M
Less funds advanced in prior year.....	-9,000,000,000	-10,400,000,000	-10,400,000,000	-10,400,000,000	-10,400,000,000	-10,400,000,000	---	---	---	M
Total, current request, FY 1991.....	31,229,502,000	37,056,183,000	34,634,766,000	36,881,301,000	36,986,394,000	36,986,394,000	---	---	+85,093,000	M
New advance, 1st quarter, FY 1992.....	10,400,000,000	12,400,000,000	11,600,000,000	13,500,000,000	13,500,000,000	13,500,000,000	+1,100,000,000	---	---	M
PATIENTS TO HEALTH CARE TRUST FUNDS										
Supplemental medical insurance.....	35,925,500,000	34,730,000,000	36,451,000,000	34,730,000,000	34,730,000,000	34,730,000,000	-1,721,000,000	---	---	M
Hospital insurance for uninsured.....	370,000,000	559,000,000	559,000,000	559,000,000	559,000,000	559,000,000	---	---	---	M
Federal uninsured payment.....	35,000,000	46,000,000	46,000,000	46,000,000	46,000,000	46,000,000	---	---	---	M
Total, Payment to Trust Funds 2/.....	36,330,500,000	35,335,000,000	37,056,000,000	35,335,000,000	35,335,000,000	35,335,000,000	-1,721,000,000	---	---	

1/ Excludes 925,000,000 in legislative additions proposed for later transmittal.

2/ Excludes legislative savings of 81,981 million proposed for later transmittal.

CONFERENCE AGREEMENT: H.R. 5257 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final -2 418	Conference Final vs House Bill	Mand Disc
PROGRAM HIGHLIGHT								
Research, demonstration, and evaluation:								
Regular program:								
Federal funds.....	12,857,000	13,000,000	13,000,000	14,000,000	13,300,000	-13,175,000	-175,000	D
Trust funds.....	(19,362,000)	(23,000,000)	(23,000,000)	(23,000,000)	(23,000,000)	(22,446,000)	(-554,000)	TP
Rural hospital transition demonstrations, trust funds.....	(17,761,000)	---	(23,000,000)	(25,000,000)	(25,000,000)	(24,398,000)	(+1,398,000)	TP
Essential access community hospitals, trust funds,	---	---	(10,000,000)	(10,000,000)	(10,000,000)	(9,759,000)	(-241,000)	TP
Subtotal, research, demonstration, & evaluation,	(50,000,000)	(36,000,000)	(69,000,000)	(72,000,000)	(71,300,000)	(69,778,000)	(+778,000)	
Medicare Contractors (Trust Funds):								
Operating funds, current.....	(1,355,342,000)	(1,410,000,000)	(1,446,500,000)	(1,461,500,000)	(1,454,000,000)	(1,418,959,000)	(-27,541,000)	TP
Contingency reserve fund.....	(98,472,000)	(173,000,000)	(136,500,000)	(136,500,000)	(136,500,000)	(133,210,000)	(-3,290,000)	TP
Subtotal, Contractors.....	(1,454,014,000)	(1,583,000,000)	(1,583,000,000)	(1,598,000,000)	(1,590,500,000)	(1,552,169,000)	(-30,831,000)	
State Certification:								
Medicare certification, trust funds.....	(91,214,000)	(135,100,000)	(155,100,000)	(155,100,000)	(155,100,000)	(151,362,000)	(-3,738,000)	TP
General program support, federal funds.....	6,469,000	8,336,000	8,336,000	8,336,000	8,336,000	8,135,000	-201,000	D
Proposed legislation, user fees, trust funds.....	---	(-155,100,000)	---	(-116,325,000)	---	---	---	
Proposed legislation, user fees, federal funds...	---	-8,336,000	---	-7,000,000	---	---	---	
Subtotal, State certification.....	(97,683,000)	---	(163,436,000)	(40,111,000)	(163,436,000)	(159,497,000)	(-3,939,000)	

CONFERENCE AGREEMENT: H.R. 9357 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comptroller	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final -2.41%	Conference House Bill	Conference Senate Bill	Hand Discrepancy
Federal Administration:									
Federal funds.....	81,509,000	83,878,000	83,878,000	80,678,000	83,678,000	81,857,000	-2,021,000	+979,000	D
Less current law user fees.....	-283,000	-248,000	-248,000	-248,000	-248,000	-248,000	---	---	D
Trust funds.....	(262,491,000)	(232,538,000)	(232,538,000)	(235,538,000)	(225,538,000)	(220,103,000)	(-12,435,000)	(-5,435,000)	TF
Proposed legislation, user fees, trust funds.....	---	(-24,567,000)	---	(-18,425,000)	---	---	---	(+18,425,000)	TF
Proposed legislation, user fees, Federal funds.....	---	-8,551,000	---	-4,913,000	---	---	---	+4,913,000	D
Subtotal, Federal Administration.....	(383,717,000)	(285,050,000)	(316,168,000)	(282,850,000)	(309,188,000)	(301,712,000)	(-14,436,000)	(+18,882,000)	
Total, Program management.....	1,945,414,000	1,904,050,000	2,131,604,000	1,992,941,000	2,134,604,000	2,083,156,000	-48,448,000	+80,215,000	
Federal funds.....	100,552,000	90,079,000	104,946,000	91,053,000	105,486,000	102,919,000	-2,047,000	+11,866,000	
Trust funds.....	(1,844,862,000)	(1,813,971,000)	(2,026,638,000)	(1,901,888,000)	(2,029,138,000)	(1,980,237,000)	(-46,401,000)	(+76,349,000)	
WHO LOAN AND LOAN GUARANTEE FUND 1/.....	4,930,000	---	---	---	---	---	---	---	D
Total, Health Care Financing Administration:	78,073,464,000	84,881,262,000	84,175,932,000	85,607,354,000	85,906,640,000	85,904,313,000	+1,728,381,000	+86,959,000	
Current year, FY 1991.....	(87,673,484,000)	(72,481,262,000)	(71,775,932,000)	(72,307,354,000)	(72,406,640,000)	(72,404,313,000)	(+678,31,000)	(+86,959,000)	
New advance, 1st quarter, FY 1992.....	110,400,000,000	(12,400,000,000)	(12,400,000,000)	(13,500,000,000)	(13,500,000,000)	(13,500,000,000)	(+1,100,000,000)	---	
Trust funds.....	(1,844,862,000)	(1,813,971,000)	(2,026,638,000)	(1,901,888,000)	(2,029,138,000)	(1,980,237,000)	(-46,401,000)	(+76,349,000)	

1/ Requirer amount not reflected correctly in President's budget.

CONFERENCE AGREEMENT: H. R. 5357 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final -2.4%	Conference Final vs House Bill	Senate Bill Diac
SOCIAL SECURITY ADMINISTRATION								
PAYMENTS TO SOCIAL SECURITY TRUST FUNDS.....	191,966,000	46,956,000	46,956,000	46,956,000	46,956,000	46,956,000	---	M
SPECIAL BENEFITS FOR DISABLED COAL MINERS								
Benefit payments.....	863,422,000	834,000,000	834,000,000	834,000,000	834,000,000	834,000,000	---	M
Administration.....	6,631,000	7,081,000	7,081,000	7,081,000	7,081,000	7,081,000	---	M
Subtotal, Black Lung, FY 1991 program level.....	870,053,000	841,081,000	841,081,000	841,081,000	841,081,000	841,081,000	---	M
Less funds advanced in prior year.....	-211,000,000	-215,000,000	-215,000,000	-215,000,000	-215,000,000	-215,000,000	---	M
Total, Black Lung, current request, FY 1991.....	659,053,000	626,081,000	626,081,000	626,081,000	626,081,000	626,081,000	---	M
New advance, 1st quarter, FY 1992.....	215,000,000	205,000,000	205,000,000	205,000,000	205,000,000	205,000,000	---	M
SUPPLEMENTAL SECURITY INCOME 1/								
Federal benefit payments.....	11,185,613,000	15,935,000,000	13,913,000,000	15,935,000,000	15,935,000,000	15,935,000,000	+2,022,000,000	M
Beneficiary services.....	13,736,000	32,317,000	27,717,000	32,317,000	32,317,000	32,317,000	+4,600,000	M
Research demonstration.....	5,375,000	5,375,000	5,375,000	5,375,000	5,375,000	5,375,000	---	M
Administration.....	1,090,131,000	1,212,602,000	1,212,602,000	1,134,626,000	1,212,602,000	1,183,376,000	-29,226,000	D
Subtotal, SSI FY 1991 program level.....	12,294,756,000	17,187,394,000	15,156,394,000	17,111,618,000	17,188,394,000	17,159,170,000	+2,000,376,000	M
Less funds advanced in prior year.....	-2,936,000,000	-3,157,000,000	-3,157,000,000	-3,157,000,000	-3,157,000,000	-3,157,000,000	---	M
Total, SSI, current request, FY 1991.....	9,358,756,000	14,030,394,000	12,001,394,000	13,954,618,000	14,031,394,000	14,002,170,000	+29,224,000	M
New advance, 1st quarter, FY 1992.....	3,137,000,000	3,350,000,000	3,350,000,000	3,350,000,000	3,350,000,000	3,350,000,000	---	M
LIMITATION ON ADMINISTRATIVE EXPENSES (Trust Funds)...	(3,837,389,000)	(4,166,974,000)	(4,166,974,000)	(4,316,974,000)	(4,316,974,000)	(4,212,935,000)	(+94,961,000)	YF
(Contingency reserve, non-add).....	(50,000,000)	(50,000,000)	(50,000,000)	(200,000,000)	(150,000,000)	(146,385,000)	(+96,385,000)	MA
Total, Social Security Administration: Federal funds.....	13,381,976,000	18,451,433,000	16,427,633,000	18,380,637,000	18,457,433,000	18,428,209,000	+2,000,576,000	+47,532,000
Current year FY 1991.....	(10,209,976,000)	(14,698,433,000)	(12,674,633,000)	(14,627,637,000)	(14,704,433,000)	(14,675,209,000)	(+2,000,576,000)	(+47,532,000)
New advance, 1st quarter FY 1992.....	(3,372,000,000)	(3,753,000,000)	(3,753,000,000)	(3,753,000,000)	(3,753,000,000)	(3,753,000,000)	---	---
Trust funds.....	(3,837,389,000)	(4,166,974,000)	(4,166,974,000)	(4,316,974,000)	(4,316,974,000)	(4,212,935,000)	(+94,961,000)	(+104,039,000)
1/ Excludes \$55,000,000 in legislative savings proposed for later transmittal.								

CONFERENCE AGREEMENT: H.R. 5257 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final - 2/4/91	Conference Final vs House Bill	Senate Bill Difference	Hand Diac
FAMILY SUPPORT ADMINISTRATION 1/									
FAMILY SUPPORT PAYMENTS TO STATES 2/									
Aid to Families with Dependent Children (AFDC).....	9,261,706,000	9,999,000,000	9,999,000,000	10,531,000,000	10,531,000,000	10,531,000,000	+532,000,000	---	M
Payments to territories.....	16,346,000	16,346,000	16,346,000	16,346,000	16,346,000	16,346,000	---	---	M
Emergency assistance, incl. welfare hotel demos.....	204,000,000	194,000,000	194,000,000	204,700,000	204,700,000	204,700,000	+10,700,000	---	M
Repatriation.....	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	---	---	M
State and local welfare administration.....	1,304,300,000	1,471,900,000	1,471,900,000	1,496,300,000	1,496,300,000	1,496,300,000	+24,400,000	---	M
Work activities / child care.....	206,000,000	489,000,000	489,000,000	412,000,000	412,000,000	412,000,000	-77,000,000	---	M
Regulatory savings.....	---	-35,000,000	-35,000,000	---	---	---	+35,000,000	---	M
Subtotal, Welfare payments.....	11,193,552,000	12,136,246,000	12,136,246,000	12,651,346,000	12,651,346,000	12,651,346,000	+515,100,000	---	---
Child Support Enforcement:									
State and local administration.....	1,059,000,000	1,197,000,000	1,197,000,000	1,197,000,000	1,197,000,000	1,197,000,000	---	---	M
Federal incentive payments.....	276,000,000	332,000,000	332,000,000	332,000,000	332,000,000	332,000,000	---	---	M
Less federal share collections.....	-836,000,000	-1,008,000,000	-1,008,000,000	-1,008,000,000	-1,008,000,000	-1,008,000,000	---	---	M
Subtotal, Child support.....	499,000,000	521,000,000	521,000,000	521,000,000	521,000,000	521,000,000	---	---	---
Total, Payments, FY 1991 program level.....	11,692,552,000	12,657,246,000	12,657,246,000	13,172,346,000	13,172,346,000	13,172,346,000	+515,100,000	---	---
Less funds advanced in previous years.....	-2,700,000,000	-3,000,000,000	-3,000,000,000	-3,000,000,000	-3,000,000,000	-3,000,000,000	---	---	M
Total, Payments, current request, FY 1991.....	8,992,552,000	9,657,246,000	9,657,246,000	10,172,346,000	10,172,346,000	10,172,346,000	+515,100,000	---	---
New advance, 1st quarter, FY 1992.....	3,000,000,000	3,300,000,000	3,300,000,000	3,300,000,000	3,300,000,000	3,300,000,000	---	---	M

1/ Exclude Administration proposal to shift USDA Fiscal Assistance to Puerto Rico Program to FSA.

2/ Exclude legislative savings of \$31.4 million proposed for later transmittal.

CONFERENCE MEMORANDUM: H.R. 5257 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final - H	Conference Final - S	Final House Bill	Final Senate Bill	Final Bic
PAYMENTS TO STATES FOR AFDC WORK PROGRAMS 1/										
New Jobs Activities Program 2/.....	443,038,000	1,000,000,000	1,000,000,000	1,004,500,000	1,000,000,000	1,000,000,000	---	---	-6,500,000	M
WIF Phaseout.....	31,200,000	---	---	---	---	---	---	---	---	D
Total, AFDC work programs.....	474,238,000	1,000,000,000	1,000,000,000	1,004,500,000	1,000,000,000	1,000,000,000	---	---	-6,500,000	
LOW INCOME HOME ENERGY ASSISTANCE										
Emergency Assistance Block Grant 3/.....	(1,393,000,000)	(1,050,000,000)	DEFER	(1,450,000,000)	(1,450,000,000)	(1,415,055,000)	(1,415,055,000)	(1,415,055,000)	(-34,945,000)	D
Emergency grants.....	(50,000,000)	---	DEFER	---	---	---	---	---	---	D
Total, Low Income Home Energy Assistance.....	(1,443,000,000)	(1,050,000,000)	DEFER	(1,450,000,000)	(1,450,000,000)	(1,415,055,000)	(1,415,055,000)	(1,415,055,000)	(-34,945,000)	
EMERGENCY CONTINGENCY FUND										
Contingency (non-add).....	---	---	---	(200,000,000)	---	---	---	---	(-200,000,000)	RM
Budget authority.....	---	---	---	---	200,000,000	195,180,000	195,180,000	195,180,000	195,180,000	D
REFUGEE AND EXTRASTAY ASSISTANCE										
Cash and medical assistance 4/.....	(210,000,000)	(210,000,000)	DEFER	(210,000,000)	(210,000,000)	(234,216,000)	(234,216,000)	(234,216,000)	(-24,216,000)	D
Social services.....	(75,000,000)	(75,000,000)	DEFER	(95,000,000)	(95,000,000)	(82,932,000)	(82,932,000)	(82,932,000)	(-2,068,000)	D
Voluntary agency program.....	(40,000,000)	(40,000,000)	DEFER	(45,000,000)	(40,000,000)	(39,038,000)	(39,038,000)	(39,038,000)	(-5,962,000)	D
Preventive health.....	(5,770,000)	(5,770,000)	DEFER	(6,000,000)	(5,770,000)	(5,631,000)	(5,631,000)	(5,631,000)	(-2,369,000)	D
Targeted assistance.....	(44,052,000)	(38,052,000)	DEFER	(50,000,000)	(50,000,000)	(48,795,000)	(48,795,000)	(48,795,000)	(-1,205,000)	D
Total, Refugee Resettlement.....	(374,822,000)	(348,822,000)	DEFER	(396,000,000)	(396,000,000)	(410,630,000)	(410,630,000)	(410,630,000)	(-12,630,000)	

1/ Reflects reprogramming approved 4/11/90.

2/ Senate recommendation includes \$6,500,000 for job creation demonstration authorized under section 505 of the Family Support Act.

3/ Senate and conference recommendation includes \$74,610,000 for obligation September 30, 1991.

4/ Includes State administrative costs.

CONFERENCE AGREEMENT: H.R. 5257 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

STATE LOCALIZATION IMPACT ASSISTANCE GRANTS									
	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference		Conference Final		Mand
					Initial	Final -2.4%	House Bill	Senate Bill	Dis
Current year.....	-587,424,000	-581,070,000	---	-566,894,000	-566,894,000	-566,894,000	-566,894,000	---	D
FY 1992 advance.....	555,244,000	-555,244,000	---	579,034,000	579,034,000	565,079,000	565,079,000	-13,955,000	D
Total.....	-12,180,000	-1,116,314,000	---	12,180,000	12,180,000	-1,775,000	-1,775,000	-13,955,000	
COMMUNITY SERVICES BLOCK GRANT									
Grants to States for Community Services.....	(333,085,000)	---	DEFER	(368,000,000)	(358,000,000)	(349,372,000)	(349,372,000)	(-18,628,000)	D
Nonfederal service grants.....	(21,855,000)	(33,959,000)	DEFER	(34,000,000)	(34,000,000)	(33,181,000)	(33,181,000)	(-819,000)	D
Advance funding for FY 1991.....	(8,041,000)	---	DEFER	---	---	---	---	---	D
Discretionary funds:									
Community economic development.....	(20,158,000)	---	DEFER	(21,000,000)	(21,000,000)	(20,494,000)	(20,494,000)	(-506,000)	D
Rural housing.....	(3,994,000)	---	DEFER	(4,200,000)	(4,200,000)	(4,099,000)	(4,099,000)	(-101,000)	D
Farmworker assistance.....	(2,934,000)	---	DEFER	(3,100,000)	(3,100,000)	(3,025,000)	(3,025,000)	(-75,000)	D
National youth sports, regular activities.....	(10,618,000)	---	DEFER	(11,100,000)	(11,100,000)	(10,832,000)	(10,832,000)	(-268,000)	D
Technical assistance.....	(235,000)	---	DEFER	(250,000)	(250,000)	(244,000)	(244,000)	(-6,000)	D
Subtotal, discretionary funds.....	(37,999,000)	---	DEFER	(39,650,000)	(39,650,000)	(38,684,000)	(38,684,000)	(-956,000)	
Community Partnerships.....	(3,495,000)	---	DEFER	(4,150,000)	(4,150,000)	(4,050,000)	(4,050,000)	(-100,000)	D
Community Food and Nutrition.....	(2,406,000)	---	DEFER	(2,500,000)	(2,500,000)	(2,440,000)	(2,440,000)	(-60,000)	D
Total, Community services.....	(396,821,000)	(33,959,000)	DEFER	(448,300,000)	(438,300,000)	(437,737,000)	(437,737,000)	(-20,563,000)	

CONFERENCE AGREEMENT: H.R. 5357 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final -2.4%	Conference Final vs House Bill	Senate Bill	Need Bill
PROGRAM ADMINISTRATION									
Federal Administration.....	75,628,000	74,950,000	74,950,000	75,450,000	75,450,000	73,432,000	-1,318,000	-1,018,000	0
Proposed user fees.....	---	-2,000,000	-1,000,000	-1,000,000	-1,000,000	-1,000,000	---	---	0
Research & evaluation.....	9,825,000	4,250,000	6,250,000	8,750,000	11,000,000	10,735,000	+4,485,000	+1,985,000	0
Total, program administration.....	85,453,000	77,200,000	80,200,000	83,200,000	85,450,000	83,367,000	+2,187,000	+187,000	---
Total, Family Support Administration.....	12,940,063,000	12,918,132,000	14,037,446,000	14,574,226,000	14,769,976,000	14,749,116,000	+711,672,000	+174,892,000	---
Current year.....	(8,984,819,000)	(10,173,376,000)	(10,737,446,000)	(10,695,192,000)	(10,890,942,000)	(10,884,039,000)	(+146,393,000)	(+186,847,000)	---
FY 1992.....	(3,555,244,000)	(2,744,756,000)	(3,300,000,000)	(3,879,034,000)	(3,879,034,000)	(3,865,079,000)	(+565,079,000)	(+13,955,000)	---
Activities not considered by House.....	(2,214,643,000)	(1,452,781,000)	BEPER	(2,296,300,000)	(2,309,070,000)	(2,253,422,000)	(+2,253,422,000)	(+42,878,000)	---
Total.....	(14,754,706,000)	(14,370,913,000)	(14,037,446,000)	(16,870,526,000)	(17,079,046,000)	(17,002,540,000)	(+2,965,094,000)	(+132,014,000)	---

CONFERENCE AGREEMENT: H.R. 5257 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final - 2-4-91	Conference House Bill	Conference Senate Bill	Head House Bill
ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES									
SOCIAL SERVICES BLOCK GRANT (TITLE III).....	2,762,300,000	2,800,000,000	2,800,000,000	2,800,000,000	2,800,000,000	2,800,000,000	---	---	W
HUMAN DEVELOPMENT SERVICES									
Programs for Children, Youth, and Families:									
Head start.....	(1,552,000,000)	(1,886,315,000)	DEPER	(2,000,000,000)	(2,000,000,000)	(1,951,800,000)	(+1,951,800,000)	(-48,200,000)	D
Child development associate scholarships.....	(1,431,000)	(1,431,000)	DEPER	(1,431,000)	(1,431,000)	(1,397,000)	(+1,397,000)	(-34,000)	D
Family crisis program:									
Child abuse state grants.....	11,567,000	11,523,000	20,000,000	20,000,000	20,000,000	19,518,000	-482,000	-482,000	D
Child abuse challenge grants.....	4,934,000	4,934,000	5,000,000	5,000,000	5,500,000	5,367,000	+367,000	-133,000	D
Runaway and homeless youth.....	28,765,000	28,765,000	36,000,000	36,000,000	36,000,000	35,132,000	-868,000	-868,000	D
Family violence.....	8,273,000	8,273,000	13,273,000	11,000,000	11,000,000	10,735,000	-2,538,000	-265,000	D
Abandoned infants assistance.....	9,867,000	9,867,000	9,867,000	12,867,000	12,867,000	12,957,000	+2,690,000	-310,000	D
Emergency protection grants - substance abuse.	---	---	20,000,000	---	20,000,000	19,518,000	-482,000	+19,518,000	D
Subtotal, family crisis.....	63,426,000	63,382,000	104,140,000	85,367,000	105,367,000	102,827,000	-1,313,000	+17,460,000	
Dependent care planning and development.....	(13,178,000)	(13,178,000)	DEPER	(13,500,000)	(13,500,000)	(13,175,000)	(+13,175,000)	(-325,000)	D
Child welfare services.....	252,648,000	300,000,000	280,000,000	300,000,000	280,000,000	273,252,000	-6,748,000	-26,748,000	D
Less amounts derived by transfer.....	---	-47,352,000	---	-47,352,000	-37,352,000	-37,352,000	-37,352,000	+20,000,000	D
Subtotal, child welfare services.....	252,648,000	252,648,000	280,000,000	252,648,000	252,648,000	245,900,000	-4,100,000	-6,748,000	
Subtotal.....	316,074,000	316,030,000	384,140,000	338,015,000	358,015,000	348,737,000	-35,413,000	+10,712,000	

CONFERENCE AGREEMENT, H. R. 5257 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final -2.4%	Conference Final vs House Bill	Conference Final vs Senate Bill	Need Disc
Programs for the Aging:									
Grants to States:									
Supportive services and centers.....	271,987,000	272,961,000	298,000,000	298,000,000	298,000,000	270,818,000	-7,182,000	-7,182,000	D
Ombudsman activities.....	973,000	---	3,000,000	6,000,000	5,500,000	-5,367,000	+2,367,000	-633,000	D
Nutrition:									
Congregate meals.....	351,935,000	351,935,000	370,000,000	370,000,000	370,000,000	361,083,000	-8,917,000	-8,917,000	D
Home-delivered meals.....	70,981,000	70,981,000	90,000,000	90,000,000	90,000,000	87,831,000	-2,169,000	-2,169,000	D
Federal Council on Aging 1/.....	---	---	185,000	---	185,000	181,000	-4,000	+181,000	D
Grants to Indiana.....	12,541,000	12,541,000	14,000,000	16,000,000	15,000,000	14,639,000	+639,000	-1,361,000	D
Preli elderly in-home services.....	5,756,000	5,756,000	5,756,000	7,000,000	7,000,000	6,831,000	+1,075,000	-169,000	D
Subtotal, Aging programs.....	722,183,000	722,184,000	780,941,000	787,000,000	785,685,000	786,750,000	-14,91,000	-20,250,000	
Developmental disabilities program:									
State grants.....	(61,939,000)	(61,939,000)	DEFER	(66,000,000)	(66,000,000)	(64,409,000)	(-1,591,000)	(-1,591,000)	D
Protection and advocacy.....	(20,484,000)	(20,484,000)	DEFER	(21,500,000)	(21,500,000)	(20,982,000)	(-1,20,982,000)	(-1,20,982,000)	D
Subtotal, Developmental disabilities.....	(82,423,000)	(82,423,000)	DEFER	(87,500,000)	(87,500,000)	(85,391,000)	(-2,109,000)	(-2,109,000)	
Native American Programs.....	31,711,000	31,711,000	34,200,000	34,200,000	34,200,000	33,376,000	824,000	-834,000	D

1/ President's budget proposes to fund under Program direction.

CONFERENCE AGREEMENT: H.R. 5357 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final	FY 1991 House Bill	Conference Final	House Bill	Senate Bill	House Difference
Human services research, training & demonstration: Comprehensive child development centers.....	24,668,000	24,668,000	24,668,000	25,000,000	25,000,000	24,398,000	24,398,000	-270,000	-270,000	-602,000	D
Child abuse discretionary activities.....	13,478,000	13,523,000	15,000,000	15,000,000	15,000,000	14,639,000	14,639,000	-361,000	-361,000	-361,000	D
Runaway youth - transitional living.....	9,887,000	9,887,000	9,887,000	10,500,000	10,184,000	9,939,000	9,939,000	+72,000	+72,000	-561,000	D
Runaway youth activities - drugs.....	14,801,000	14,801,000	14,801,000	15,500,000	15,151,000	14,786,000	14,786,000	-15,000	-15,000	-714,000	D
Youth gang substance abuse.....	14,801,000	14,801,000	14,801,000	15,500,000	15,151,000	14,786,000	14,786,000	-15,000	-15,000	-714,000	D
Temporary childcare/crisis nurseries.....	8,328,000	8,328,000	8,328,000	11,328,000	11,328,000	11,093,000	11,093,000	2,227,000	2,227,000	-273,000	D
Child welfare training.....	3,647,000	3,647,000	3,647,000	3,647,000	3,647,000	3,559,000	3,559,000	-88,000	-88,000	-88,000	D
Child welfare research.....	7,517,000	13,517,000	13,517,000	8,000,000	8,000,000	7,807,000	7,807,000	-5,710,000	-5,710,000	-193,000	D
Adoption opportunities.....	6,736,000	6,736,000	13,000,000	13,000,000	13,000,000	13,487,000	13,487,000	-313,000	-313,000	-313,000	D
Aging research, training and special projects.....	25,332,000	26,332,000	27,332,000	27,832,000	27,582,000	26,917,000	26,917,000	-415,000	-415,000	-915,000	D
Social services research.....	3,475,000	3,475,000	3,975,000	3,975,000	3,975,000	3,879,000	3,879,000	-96,000	-96,000	-96,000	D
Developmental disabilities special projects.....	(3,862,000)	(2,862,000)	DEFEAT	(3,100,000)	(3,100,000)	(3,025,000)	(3,025,000)	(+3,025,000)	(+3,025,000)	1-75,000	D
Developmental disabilities university affiliated programs.....	(13,182,000)	(13,182,000)	DEFEAT	(14,250,000)	(14,250,000)	(13,907,000)	(13,907,000)	(+13,907,000)	(+13,907,000)	(-143,000)	D
Total, Human Services Res. Trng & demonstration.....	132,630,000	139,695,000	148,938,000	149,282,000	148,018,000	144,452,000	144,452,000	-4,484,000	-4,484,000	-4,830,000	D
Program direction.....	68,313,000	71,149,000	75,000,000	75,000,000	74,000,000	72,217,000	72,217,000	-2,783,000	-2,783,000	-783,000	D
Subtotal, Human Development Services.....	1,270,911,000	1,280,749,000	1,423,217,000	1,381,497,000	1,399,918,000	1,365,322,000	1,365,322,000	-57,693,000	-57,693,000	-15,975,000	D
Child care: FY 1991 1/.....	---	---	DEFEAT	(1,139,000,000)	(750,000,000)	(731,925,000)	(731,925,000)	(+731,925,000)	(+731,925,000)	(-427,075,000)	D
FY 1992.....	---	---	DEFEAT	(41,000,000)	---	---	---	---	---	(-41,000,000)	D
Total, Human Development Services.....	1,270,911,000	1,280,749,000	1,423,217,000	1,381,497,000	1,399,918,000	1,365,322,000	1,365,322,000	-57,693,000	-57,693,000	-15,975,000	D
Activities not considered by House.....	(1,665,086,000)	(1,999,401,000)	DEFEAT	(3,319,781,000)	(2,869,781,000)	(2,800,620,000)	(2,800,620,000)	(+2,800,620,000)	(+2,800,620,000)	(-319,161,000)	D
Total.....	(2,935,997,000)	(3,260,150,000)	(1,423,217,000)	(4,701,278,000)	(4,269,699,000)	(4,166,142,000)	(4,166,142,000)	(+2,742,925,000)	(+2,742,925,000)	(-335,136,000)	D

1/ Senate makes available for child care, Sept. 15, 1991.
Conference makes available Sept. 7, 1991.

CONFERENCE AGREEMENT: H.R. 5257 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final - H.R.	Conference Final - S.	House Bill	Senate Bill	Hand Spec
PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE										
Posters care.....	1,200,061,000	1,830,360,000	1,877,712,000	1,793,186,000	1,813,186,000	1,813,186,000	64,526,000	20,000,000	W	
Proposed legislation.....		-160,909,000							D	
Adoption assistance.....	124,835,000	150,480,000	150,480,000	189,832,000	189,832,000	189,832,000	39,352,000		W	
Independent living.....	50,000,000	60,000,000	60,000,000	60,000,000	60,000,000	60,000,000			W	
Prior year claims.....		544,000,000	544,000,000	530,911,000	530,911,000	530,911,000	-23,089,000		W	
Transfer to child welfare service.....		47,352,000		47,352,000	27,352,000	27,352,000	27,352,000	-20,000,000	W	
Total, Payments to States.....	1,374,916,000	2,431,281,000	2,432,192,000	2,411,281,000	2,411,281,000	2,411,281,000	-20,911,000			
Total, Asst. Sec. for Human Development.....	5,408,027,000	6,552,032,000	6,855,409,000	6,792,778,000	6,811,199,000	6,776,803,000	-78,606,000	-15,975,000		
Activities not considered by House.....	(1,645,086,000)	(1,999,403,000)	DEFER	(3,319,781,000)	(2,869,781,000)	(2,800,630,000)	(2,800,630,000)	(-519,161,000)		
Total.....	(7,073,113,000)	(8,531,433,000)	(6,855,409,000)	(10,112,559,000)	(9,680,940,000)	(9,577,433,000)	(2,722,014,000)	(-539,136,000)		

CONFERENCE AGREEMENT: H.R. 5357 - FY 1991 APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES

	FY 1990 Comparable	FY 1991 Budget Request	FY 1991 House Bill	FY 1991 Senate Bill	Conference Initial	Conference Final	Conference Final vs House Bill	Final vs Senate Bill	Final Dif
Total, Department of Health and Human Services:	122,503,081,000	136,175,978,000	135,916,000,000	139,760,731,000	140,352,392,000	139,935,955,000	+4,009,947,000	+164,834,000	
Federal Funds:									
Current Year FY 1991:	(105,156,593,000)	(117,278,222,000)	(116,483,000,000)	(118,428,897,000)	(119,220,358,000)	(118,807,478,000)	(+2,344,468,000)	(+178,779,000)	
FY 1992:	(17,346,486,000)	(18,897,756,000)	(19,453,000,000)	(21,132,034,000)	(21,132,034,000)	(21,118,079,000)	(+1,865,079,000)	(-13,955,000)	
Activities not considered by House:	(4,717,810,000)	(4,338,915,000)	0	0	0	0	0	0	
Total:	(127,220,891,000)	(140,514,993,000)	(135,926,000,000)	(146,967,997,000)	(146,781,773,000)	(146,160,955,000)	(+10,234,947,000)	(-787,042,000)	
Trust funds:	(5,767,111,000)	(6,088,805,000)	(6,279,322,000)	(6,264,572,000)	(6,373,971,000)	(6,218,987,000)	(+60,338,000)	(-28,583,000)	

Finder's Aid
P.L. 101-597 (104 Stat. 3013) Approved November 16, 1990
National Health Service Corps Revitalization Act, Amendments of 1990

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H.Rep. 101-642</u>	<u>H.C.Rep. 101-945</u>	<u>S.Rep. 101-370</u>
Peer Review - Obligations of Health Care Practitioners (conforming amendment)	1156(b)(5)	401(c)(1)	3035	--	--	21, 47-48
Supplementary Medical Insurance Benefits - Payment (conforming amendment)	1833(m)	401(c)(2)	3035	--	--	21, 48
Supplementary Medical Insurance Benefits - Payment (conforming amendment)	1842(b)(4)(F)	401(c)(2)	3035	--	--	21, 48
Medicare - Definitions - Medical and Other Health Services (conforming amendment)	1861(s)(2) (K)(i)	401(c)(2)	3035	--	--	21, 48-49
Medicare - Definitions - Rural Health Clinic Services (conforming amendment)	1861(aa)(1)(J)	401(c)(2)	3035	--	--	21, 49

Public Law 101-597
101st Congress

An Act

To amend the Public Health Service Act to revise and extend the program for the National Health Service Corps, and to establish certain programs of grants to the States for improving health services in the States.

Nov. 16, 1990
[H.R. 4487]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

National Health
Service Corps
Revitalization
Amendments
of 1990.

SECTION 1. SHORT TITLE.

This Act may be cited as the “National Health Service Corps Revitalization Amendments of 1990”

42 USC 201
note.

TITLE I—REVISIONS IN GENERAL PROGRAM FOR NATIONAL HEALTH SERVICE CORPS

SEC. 101. NATIONAL HEALTH SERVICE CORPS.

(a) PROVISION OF PRIMARY HEALTH SERVICES.—Section 331(a) of the Public Health Service Act (42 U.S.C. 254d(a)) is amended—

(1) in the matter preceding subparagraph (A) of paragraph (1)—

(A) by inserting “(1)” after the subsection designation; and

(B) by striking “There is” and all that follows and inserting the following: “For the purpose of eliminating health manpower shortages in health manpower shortage areas, there is established, within the Service, the National Health Service Corps, which shall consist of—”;

(2) by striking “States,” at the end of paragraph (1)(C) and all that follows and inserting “States.”; and

(3) by adding at the end the following new paragraphs:

“(2) The Corps shall be utilized by the Secretary to provide primary health services in health manpower shortage areas.

“(3) For purposes of this subpart and subpart III:

“(A) The term ‘Corps’ means the National Health Service Corps.

“(B) The term ‘Corps member’ means each of the officers, employees, and individuals of which the Corps consists pursuant to paragraph (1).

“(C) The term ‘health manpower shortage area’ has the meaning given such term in section 332(a).

“(D) The term ‘primary health services’ means health services regarding family medicine, internal medicine, pediatrics, obstetrics and gynecology, dentistry, or mental health, that are provided by physicians or other health professionals.”.

TITLE IV—HEALTH PROFESSIONAL SHORTAGE AREAS

SEC. 401. MODIFICATION REGARDING TERM “HEALTH MANPOWER SHORTAGE AREA”.

(b) PUBLIC HEALTH SERVICE ACT.—

(1) The Public Health Service Act, as amended by the preceding provisions of this Act, is amended in each of the provisions specified in paragraph (2)—

(A) by striking “health manpower shortage area” each place such term appears and inserting “health professional shortage area”; and

(B) in the case of each variation of the term “health manpower shortage area” that results from the capitalization of any of the letters of such term, from the use of the plural, from the use of the possessive, or from the use of different forms of typeface, or from any combination thereof, by striking each such variation each place the variation appears and inserting the analogous variation of the term “health professional shortage area”.

(2) The provisions of the Public Health Service Act referred to in paragraph (1) are sections 303(d)(2)(B), 331, 332, 333, 333A, 334, 335, 336(a), 336A, 338A, 338B, 338C, 338D, 338G(a)(1), 338I, 735, 741(f)(1)(C), 759(a), 781(a)(2)(B)(iii), and 822.

42 USC 242a,
254d-254i,
254l-254n, 254p,
254q-1, 294h,
294n, 294aa,
295q-1, 296m.

(b) UNIFORMED SERVICES HEALTH PROFESSIONS REVITALIZATION ACT OF 1972.—Section 2123(e) of title 10, United States Code, is amended by striking out “an area of health manpower shortage” and inserting in lieu thereof “a health professional shortage area”.

(c) SOCIAL SECURITY ACT.—The Social Security Act is amended—

(1) in section 1156(b)(5), by striking “health manpower shortage area (HMSA)” and inserting “health professional shortage area”; and

(2) in sections 1833(m), 1842(b)(4)(F), and 1861 (42 U.S.C. 1395l(m), 1395u(b)(4)(F), and 1395x), by striking “health manpower shortage area” each place such term appears and inserting “health professional shortage area”.

(d) COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971.—Section 202 of the Comprehensive Health Manpower Training Act of 1971 (42 U.S.C. 3505d) is amended—

(1) by striking out the section heading and inserting in lieu thereof the following:

“NATIONAL HEALTH PROFESSIONAL SHORTAGE CLEARINGHOUSE”;

and

(2) in subsection (a), by striking out “Manpower” and inserting in lieu thereof “Professional”.

(e) HEAD START ACT.—Section 645(a)(2)(B) of the Head Start Act (42 U.S.C. 9840(a)(2)(B)) is amended by striking “health manpower shortage area” and inserting “health professional shortage area”.

TITLE V—GENERAL PROVISIONS

42 USC 242a
note.

SEC. 501. EFFECTIVE DATE.

This Act and the amendments made by this Act shall take effect October 1, 1990, or upon the date of the enactment of this Act, whichever occurs later.

Approved November 16, 1990.

LEGISLATIVE HISTORY—H.R. 4487 (S. 2617):

HOUSE REPORTS: No. 101-642 (Comm. on Energy and Commerce) and No. 101-945 (Comm. of Conference).

SENATE REPORTS: No. 101-370 accompanying S. 2617 (Comm. on Labor and Human Resources).

CONGRESSIONAL RECORD, Vol. 136 (1990):

July 30, considered and passed House.

Aug. 4, considered and passed Senate, amended, in lieu of S. 2617.

Oct. 26, House and Senate agreed to conference report.

NATIONAL HEALTH SERVICE CORPS REVITALIZATION
ACT OF 1990

JULY 16 (legislative day, JULY 10), 1990.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 2617]

The Committee on Labor and Human Resources, to which was referred the bill (S. 2617) having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

SUMMARY OF THE BILL

As reported by the Committee, the National Health Service Corps Revitalization Act of 1990 (S. 2617) extends the authority of National Health Service Corps (NHSC) through FY 1994. It authorizes appropriations of \$65 million for FY 1991, and such sums as needed in FY 1992, 1993, 1994 for the NHSC field program. The bill also includes provisions to strengthen NHSC efforts to recruit and retain health care professionals by establishing a set of priorities for selecting applicants that would target disadvantaged and minority students, residents of medically underserved areas, primary care providers, and non-physician providers (nurses, nurse practitioners, nurse midwives, and other types of non-physician providers). The bill also requires that funds be set aside specifically for recruiting and retaining nurses, nurse practitioners, nurse midwives, and other non-physician health care providers in the NHSC.

S. 2617 requires the Secretary to include a statement listing all the factors used in the selection of applicants and the assignment of Corps members along with the NHSC applications and contracts provided to individuals interested in participating in the Corps. The bill sets a number of priorities for awarding scholarships and

(C) by striking out "or part" in paragraph (3).

SEC. 16. CONFORMING AMENDMENTS.

(a) **UNIFORMED SERVICES HEALTH PROFESSIONS REVITALIZATION ACT OF 1972.**—Section 2123(e) of title 10, United States Code, is amended by striking out "an area of health manpower shortage" and inserting in lieu thereof "a health professional shortage area".

(b) **PUBLIC HEALTH SERVICE ACT.**—

(1) Sections 303(d)(2)(B), 331, 333, 334, 335, 336(a), 336A, 338A, 338B, 338C, 338D, 338F(a)(1), 735, 741(f)(1)(C), 759(a), 781(a)(2)(B)(iii), and 822 of the Public Health Service Act (42 U.S.C. 242a(d)(2)(B), 254d, 254f, 254g, 254h, 254h-1(a), 254i, 254l, 254l-1, 254m, 254n, 254p(a)(1), 294h, 294n(f)(1)(C), 294aa(a), 295g-1(a)(2)(B)(iii), and 296m) are amended by striking out "health manpower shortage area" each place such appears and inserting in lieu thereof "health professional shortage area".

(2) Section 332 of the Public Health Service Act (42 U.S.C. 254e) is amended—

(A) by striking out the section heading and inserting in lieu thereof the following:

"DESIGNATION OF HEALTH PROFESSIONAL SHORTAGE AREAS";

and

(B) by striking out "health manpower shortage area" each place it appears and inserting in lieu thereof "health professional shortage area".

(c) **SOCIAL SECURITY ACT.**—The Social Security Act is amended—

(1) in section 1156(b)(5) (42 U.S.C. 1320c-5(b)(5)), by striking out "health manpower shortage area (HMSA)" and inserting in lieu thereof "health professional shortage area"; and

(2) in sections 1833(m), 1842(b)(4)(F), and 1861 (42 U.S.C. 1395l(m), 1395u(b)(4)(F), and 1395x), by striking out "health manpower shortage area" each place it appears and inserting in lieu thereof "health professional shortage area".

(d) **COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971.**—Section 202 of the Comprehensive Health Manpower Training Act of 1971 (42 U.S.C. 3505d) is amended—

(1) by striking out the section heading and inserting in lieu thereof the following:

"NATIONAL HEALTH PROFESSIONAL SHORTAGE CLEARINGHOUSE";

and

(2) in subsection (a), by striking out "Manpower" and inserting in lieu thereof "Professional".

(e) **HEAD START ACT.**—Section 645(a)(2)(B) of the Head Start Act (42 U.S.C. 9840(a)(2)(B)) is amended by striking out "health manpower shortage area" and inserting in lieu thereof "health professional shortage area".

NATIONAL HEALTH SERVICE CORPS—COMMITTEE VIEWS

The Committee believes that rebuilding and revitalizing the Corps must be a high priority in order to address the ongoing problem of geographic maldistribution of physicians and primary

(iii) projects designed to prepare, through preceptorships and other programs, individuals subject to a service obligation under the National Health Service Corps scholarship program to effectively provide health services in [health manpower shortage areas.] *health professional shortage areas.*

* * * * *

NURSE PRACTITIONER AND NURSE MIDWIFE PROGRAMS

SEC. 822. (a)(1) * * *

* * * * *

programs for the training of nurse practitioners and nurse midwives. The Secretary shall give special consideration to applications for grants or contracts for programs for the training of nurse practitioners and nurse midwives who will practice in [health manpower shortage areas] *health professional shortage area* (designated under section 332) and for the education of nurse practitioners which emphasize education respecting the special problems of geriatric patients (particularly problems in the delivery of preventive care, acute care, and long-term care (including home health care and institutional care) to such patients) and education to meet the particular needs of nursing home patients and patients who are confined to their homes.

* * * * *

considering applications for a grant or contract under this subsection, the Secretary shall give special consideration to applications for traineeships to train individuals who are residents of [health manpower shortage areas] *health professional shortage area* designated under section 332.

* * * * *

(3) A traineeship funded under this subsection shall not be awarded unless the recipient enters into a commitment with the Secretary to practice as a nurse practitioner or nurse midwife in a [health manpower shortage area] *health professional shortage area* (designated under section 332) or in a public health care facility for a period equal to one month for each month for which the recipient receives such a traineeship.

.....

SOCIAL SECURITY ACT

* * * * *

SEC. 1156. (b) * * *

* * * * *

(5) Before the Secretary may effect an exclusion under paragraph (2) in the case of a provider or practitioner located in a rural [health manpower shortage area (HMSA)] *health professional shortage area* or in a county with a population of less than 70,000, the provider or practitioner adversely affected by the determination is entitled to a hearing before an administrative law judge (described in section 205(b)) respecting whether the provider or practitioner should be able to continue furnishing services to individuals

entitled to benefits under this Act, pending completion of the administrative review procedure under paragraph (4). If the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to such individuals if permitted to continue furnishing such services, the Secretary shall not effect the exclusion under paragraph (2) until the provider or practitioner has been provided reasonable notice and opportunity for an administration hearing thereon under paragraph (4).

* * *
SEC. 1833. * * *

(m) In the case of physicians' services furnished to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a class 1 or class 2 [health manpower shortage area,] *health professional shortage area*, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 5 percent of the payment amount for the service under this part.

* * *
SEC. 1842. (b)(4) * * *

(F) In determining the customary charges for physicians' services (other than primary care services and other than services furnished in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a [health manpower shortage area] *health professional shortage area* for which adequate actual charge data are not available because a physician has not yet been in practice for a sufficient period of time, the Secretary shall set a customary charge at a level no higher than 80 percent of the prevailing charge for a service.

* * *
SOCIAL SECURITY ACT—SECTION 1861

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

* * *
Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * *

(K)(i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(3)) under the supervision of a physician (as so defined) (I) in a hospital, skilled nursing facility, or nursing facility (as defined in section 1919(a)), (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a [health manpower shortage area,] *health professional shortage area*, and which the physician assistant is legally authorized to perform by the State in which the services are performed, and

* * * * *

Rural Health Clinic Services

(aa)(1) The term "rural health clinic services" means—

(A) * * *

* * * * *

(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the Secretary either (I) as an area with a shortage of personal health services under section 1302(7) of the Public Health Service Act or (II) as a [health manpower shortage area] *health professional shortage area* described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.

* * * * *

COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971

* * * * *

Finder's Aid

P.L. 101-624 (104 Stat. 3359) Approved November 28, 1990
Food, Agriculture, Conservation, and Trade Act of 1990

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H.Rep 101-413</u>	<u>H.Rep. 101-415</u>	<u>H.Rep. 101-569 Part 5</u>	<u>S.Rep. 101-357</u>
Old-Age and Survivors Insurance - Evidence for Payment (technical amendment)	205(c)(2) (C)(i)(I) Redesignated as 205(c) (2)(i)	1735(a)(2) 2201(b)(2)	3791 3952	--	--	17-18	--
Old-Age and Survivors Insurance - Evidence for Payment (technical amendment)	205(c)(2) (C)(i)(II) Redesignated as 205(c) (2)(ii)	1735(a)(2) 2201(b)(2)	3791 3952	--	--	17-18	--
Old-Age and Survivors Insurance - Evidence for Payment (technical amendment)	205(c)(2) (C)(ii) Redesignated as 205(c) (2)(C)(iv)	1735(a)(1) 2201(b)(1)	3791 3951	--	--	17-18	--
Old-Age and Survivors Insurance - Evidence for Payment (technical amendment)	205(c)(2) (C)(iii) Redesignated as 205(c)(2) (C)(v)	1735(a)(1) 2201(b)(1)	3791 3951	--	--	17-18	--
Old-Age and Survivors Insurance - Evidence for Payment	205(c)(2) (C)(iii) New	1735(a)(3)	3791	--	--	17-18	--

<u>Subject</u>	<u>S.S.Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H.Rep. 101-413</u>	<u>H.Rep. 101-415</u>	<u>H.Rep. 101-569 Part 5</u>	<u>S.Rep. 101-357</u>
Old-Age and Survivors Insurance - Evidence for Payment	205(c)(2) (C)(iii) New	2201(b)(3)	3952	--	--	17-18	--
Old-Age and Survivors Insurance - Evidence for Payment (technical amendment)	205(c)(2) (C)(iv) Redesignated as 205(c)(2) (C)(vi)	1735(a)(1) 2201(b)(1)	3791 3951	--	--	17-18	--
Old-Age and Survivors Insurance - Confidentiality of Social Security Account Numbers	205(c)(2) (C)(vii) New	1735(b)	3792	--	--	17-18	--
Old-Age and Survivors Insurance - Confidentiality of Social Security Account Numbers	205(c)(2) (C)(vii) New	2201(c)	3952	--	--	17-18	--

Public Law 101-624
101st Congress

An Act

To extend and revise agricultural price support and related programs, to provide for agricultural export, resource conservation, farm credit, and agricultural research and related programs, to ensure consumers an abundance of food and fiber at reasonable prices, and for other purposes.

Nov. 28, 1990
[S. 2830]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Food, Agriculture, Conservation, and Trade Act of 1990”.

(b) **TABLE OF CONTENTS.**—The table of contents is as follows:

Food,
Agriculture,
Conservation,
and Trade Act of
1990.
7 USC 1421 note.

TITLE I—DAIRY

- Sec. 101. Milk price support and milk inventory management program for calendar years 1991 through 1995.
- Sec. 102. Milk manufacturing margin adjustment.
- Sec. 103. Minnesota-Wisconsin price series reform.
- Sec. 104. Hearings on Federal milk marketing orders.
- Sec. 105. Report of dairy product purchases.
- Sec. 106. Application of support price for milk.
- Sec. 107. Application of amendments.
- Sec. 108. Adjustments for seasonal production; hearings on amendments; determination of milk prices.
- Sec. 109. Transfer of dairy products to the military and veterans hospitals.
- Sec. 110. Extension of the dairy indemnity program.
- Sec. 111. Export sales of dairy products.
- Sec. 112. Component pricing of milk.
- Sec. 113. Adjustments in payments by handlers.
- Sec. 114. Dairy export incentive program.
- Sec. 115. Status of producer handlers.
- Sec. 116. Multiple component pricing study.

TITLE II—WOOL AND MOHAIR

- Sec. 201. Wool and mohair price support program.

TITLE III—WHEAT

- Sec. 301. Loans, payments, and acreage reduction programs for the 1991 through 1995 crops of wheat.
- Sec. 302. Nonapplicability of certificate requirements.
- Sec. 303. Suspension of land use, wheat marketing allocation, and producer certificate provisions.
- Sec. 304. Suspension of certain quota provisions.
- Sec. 305. Nonapplicability of section 107 of the Agricultural Act of 1949 to the 1991 through 1995 crops of wheat.

TITLE IV—FEED GRAINS

- Sec. 401. Loans, payments, and acreage reduction programs for the 1991 through 1995 crops of feed grains.
- Sec. 402. Nonapplicability of section 105 of the Agricultural Act of 1949 to the 1991 through 1995 crops of feed grains.
- Sec. 403. Recourse loan program for silage.
- Sec. 404. Price support for high moisture feed grains.
- Sec. 405. Calculation of refunds of advance established price payments by producers of the 1988 or 1989 crops of feed barley.

the month shall receive, in lieu of its initial allotment and its regular allotment for the following month, an allotment that is the aggregate of the initial allotment and the first regular allotment, which shall be provided in accordance with paragraphs (3) and (9) of section 11(e).”.

SEC. 1733. PERIODIC REAUTHORIZATION OF RETAIL FOOD STORES AND WHOLESALE FOOD CONCERNS.

Section 9(a) (7 U.S.C. 2018(a)) is amended—

- (1) by inserting “(1)” after the subsection designation; and
- (2) by adding at the end the following new paragraph:

“(2) The Secretary is authorized to issue regulations providing for a periodic reauthorization of retail food stores and wholesale food concerns.”

SEC. 1734. AUTHORIZATION OF WHOLESALE FOOD CONCERNS.

Section 9(b)(1) (7 U.S.C. 2018(b)(1)) is amended by inserting after the first sentence the following new sentence: “No co-located wholesale-retail food concern may be authorized to accept and redeem coupons as a retail food store, unless (A) the concern does a substantial level of retail food business, or (B) the Secretary determines that failure to authorize such a food concern as a retail food store would cause hardship to food stamp households.”.

SEC. 1735. REQUIRED SUBMISSION OF CERTAIN IDENTIFYING INFORMATION BY RETAIL FOOD STORES AND WHOLESALE FOOD CONCERNS.

(a) **IN GENERAL.**—Section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)) is amended—

- (1) by redesignating clauses (ii), (iii), and (iv) as clauses (iv), (v), and (vi), respectively;
- (2) by redesignating subclauses (I) and (II) of clause (i) as clauses (i) and (ii), respectively; and
- (3) by inserting after clause (ii) (as redesignated) the following new clause:

“(iii) In the administration of section 9 of the Food Stamp Act of 1977 (7 U.S.C. 2018) involving the determination of the qualifications of applicants under such Act, the Secretary of Agriculture may require each applicant retail store or wholesale food concern to furnish to the Secretary of Agriculture the social security account number of each individual who is an officer of the store or concern and, in the case of a privately owned applicant, furnish the social security account numbers of the owners of such applicant. No officer or employee of the Department of Agriculture shall have access to any such number for any purpose other than the establishment and maintenance of a list of the names and social security account numbers of such individuals for use in determining those applicants who have been previously sanctioned or convicted under section 12 or 15 of such Act (7 U.S.C. 2021 or 2024). The Secretary of Agriculture shall restrict, to the satisfaction of the Secretary of Health and Human Services, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States whose duties or responsibilities require access for the administration or enforcement of the Food Stamp Act of 1977. The Secretary of Agriculture shall provide such other safeguards as the Secretary of Health and Human Services determines to be

necessary or appropriate to protect the confidentiality of the social security account numbers.”.

(b) **CONFIDENTIALITY OF SOCIAL SECURITY ACCOUNT NUMBERS.**—Section 205(c)(2)(C) of such Act (as amended by subsection (a) of this section) is further amended by adding at the end the following new clause:

“(vii)(I) Social security account numbers and related records that are obtained or maintained by authorized persons pursuant to any provision of law enacted on or after October 1, 1990, shall be confidential, and no authorized person shall disclose any such social security account number or related record.

“(II) Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986 shall apply with respect to the unauthorized willful disclosure to any person of social security account numbers and related records obtained or maintained by an authorized person pursuant to a provision of law enacted on or after October 1, 1990, in the same manner and to the same extent as such paragraphs apply with respect to unauthorized disclosures of return and return information described in such paragraphs. Paragraph (4) of section 7213(a) of such Code shall apply with respect to the willful offer of any item of material value in exchange for any such social security account number or related record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

“(III) For purposes of this clause, the term ‘authorized person’ means an officer or employee of the United States, an officer or employee of any State, political subdivision of a State, or agency of a State or political subdivision of a State, and any other person (or officer or employee thereof), who has or had access to social security account numbers or related records pursuant to any provision of law enacted on or after October 1, 1990. For purposes of this subclause, the term ‘officer or employee’ includes a former officer or employee.

“(IV) For purposes of this clause, the term ‘related record’ means any record, list, or compilation that indicates, directly or indirectly, the identity of any individual with respect to whom a request for a social security account number is maintained pursuant to this clause.”.

(c) **REQUIRED SUBMISSION OF EMPLOYER IDENTIFICATION NUMBERS.**—Section 6109 of the Internal Revenue Code of 1986 (relating to identifying numbers) is amended by adding at the end the following new subsection:

“(f) **ACCESS TO EMPLOYER IDENTIFICATION NUMBERS BY SECRETARY OF AGRICULTURE FOR PURPOSES OF FOOD STAMP ACT OF 1977.**—

“(1) **IN GENERAL.**—In the administration of section 9 of the Food Stamp Act of 1977 (7 U.S.C. 2018) involving the determination of the qualifications of applicants under such Act, the Secretary of Agriculture may, subject to this subsection, require each applicant retail store or wholesale food concern to furnish to the Secretary of Agriculture the employer identification number assigned to the store or concern pursuant to this section. The Secretary of Agriculture shall not have access to any such number for any purpose other than the establishment and maintenance of a list of the names and employer identification numbers of the stores and concerns for use in determining those applicants who have been previously sanctioned or convicted under section 12 or 15 of such Act (7 U.S.C. 2021 or 2024).

SEC. 2122. ADMINISTRATION.

7 USC 6521.

(a) **REGULATIONS.**—Not later than 540 days after the date of enactment of this title, the Secretary shall issue proposed regulations to carry out this title.

(b) **ASSISTANCE TO STATE.**—

(1) **TECHNICAL AND OTHER ASSISTANCE.**—The Secretary shall provide technical, administrative, and Extension Service assistance to assist States in the implementation of an organic certification program under this title.

(2) **FINANCIAL ASSISTANCE.**—The Secretary may provide financial assistance to any State that implements an organic certification program under this title.

SEC. 2123. AUTHORIZATION OF APPROPRIATIONS.

7 USC 6522.

There are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out this title.

TITLE XXII—CROP INSURANCE AND DISASTER ASSISTANCE

Subtitle A—Crop Insurance

SEC. 2201. SUBMISSION OF SOCIAL SECURITY ACCOUNT NUMBERS AND
EMPLOYER IDENTIFICATION NUMBERS.

(a) **SUBMISSION REQUIRED.**—Section 506 of the Federal Crop Insurance Act (7 U.S.C. 1506) is amended by adding at the end the following new subsection:

“(1) **SUBMISSION OF CERTAIN INFORMATION.**—

“(1) **SOCIAL SECURITY ACCOUNT AND EMPLOYER IDENTIFICATION NUMBERS.**—The Corporation shall require, as a condition of eligibility for participation in the multiple peril crop insurance program, submission of social security account numbers, subject to the requirements of section 205(c)(2)(C)(iii) of the Social Security Act, and employer identification numbers, subject to the requirements of section 6109(f) of the Internal Revenue Code of 1986.

“(2) **NOTIFICATION BY POLICYHOLDERS.**—Each policyholder shall notify each individual or other entity that acquires or holds a substantial beneficial interest in such policyholder of the requirements and limitations under this title.

“(3) **IDENTIFICATION OF HOLDERS OF SUBSTANTIAL INTERESTS.**—The Manager of the Corporation may require each policyholder to provide to the Manager, at such times and in such manner as prescribed by the Manager, the name of each individual that holds or acquires a substantial beneficial interest in the policyholder.

“(4) **DEFINITION.**—For purposes of this subsection, the term ‘substantial beneficial interest’ means not less than 5 percent of all beneficial interests in the policyholder.”.

(b) **ACCESS BY FCIC TO SOCIAL SECURITY ACCOUNT NUMBERS.**—Section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)) is amended—

(1) by redesignating clauses (ii), (iii), and (iv) as clauses (iv), (v), and (vi), respectively;

(2) by redesignating subclauses (I) and (II) of clause (i) as clauses (i) and (ii), respectively; and

(3) by inserting after clause (ii) (as redesignated) the following new clause:

“(iii) In the administration of section 506 of the Federal Crop Insurance Act, the Federal Crop Insurance Corporation may require each policyholder and each reinsured company to furnish to the insurer or to the Corporation the social security account number of such policyholder, subject to the requirements of this clause. No officer or employee of the Federal Crop Insurance Corporation shall have access to any such number for any purpose other than the establishment of a system of records necessary for the effective administration of such Act. The Manager of the Corporation may require each policyholder to provide to the Manager, at such times and in such manner as prescribed by the Manager, the social security account number of each individual that holds or acquires a substantial beneficial interest in the policyholder. For purposes of this clause, the term ‘substantial beneficial interest’ means not less than 5 percent of all beneficial interest in the policyholder. The Secretary of Agriculture shall restrict, to the satisfaction of the Secretary of Health and Human Services, access to social security account numbers obtained pursuant to this clause only to officers and employees of the United States or authorized persons whose duties or responsibilities require access for the administration of the Federal Crop Insurance Act. The Secretary of Agriculture shall provide such other safeguards as the Secretary of Health and Human Services determines to be necessary or appropriate to protect the confidentiality of such social security account numbers. For purposes of this clause the term ‘authorized person’ means an officer or employee of an insurer whom the Manager of the Corporation designates by rule, subject to appropriate safeguards including a prohibition against the release of such social security account number (other than to the Corporation) by such person.”

(c) **CONFIDENTIALITY OF SOCIAL SECURITY ACCOUNT NUMBERS.**—Section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)) (as amended by subsection (b)) is further amended by adding at the end thereof the following new clause:

“(vii)(I) Social security account numbers and related records that are obtained or maintained by authorized persons pursuant to any provision of law, enacted on or after October 1, 1990, shall be confidential, and no authorized person shall disclose any such social security account number or related record.

“(II) Paragraphs (1), (2), and (3) of section 7213(a) of the Internal Revenue Code of 1986 shall apply with respect to the unauthorized willful disclosure to any person of social security account numbers and related records obtained or maintained by an authorized person pursuant to a provision of law enacted on or after October 1, 1990, in the same manner and to the same extent as such paragraphs as such paragraphs apply with respect to unauthorized disclosures of returns and return information described in such paragraphs. Paragraph (4) of such 7213(a) of such Code shall apply with respect to the willful offer of any item of material value in exchange for any such social security account number or related record in the same manner and to the same extent as such paragraph applies with respect to offers (in exchange for any return or return information) described in such paragraph.

“(III) For purposes of this clause, the term ‘authorized person’ means an officer or employee of the United States, an officer or employee of any State, political subdivision of a State, or agency of a State or political subdivision of a State, and any other person (or officer or employee thereof), who has or had access to social security account numbers or related records pursuant to any provision of law enacted on or after October 1, 1990. For purposes of this subclause, the term ‘officer or employee’ includes a former officer or employee.

“(IV) For purposes of this clause, the term ‘related record’ means any record, list, or compilation that indicates, directly or indirectly, the identity of any individual with respect to whom a social security account number is maintained pursuant to this clause.”

(d) ACCESS BY FCIC TO EMPLOYER IDENTIFICATION NUMBERS.—Section 6109 of the Internal Revenue Code of 1986 (relating to identifying numbers) is amended by adding at the end thereof the following new subsection: 26 USC 6109.

“(f) ACCESS TO EMPLOYER IDENTIFICATION NUMBERS BY FEDERAL CROP INSURANCE CORPORATION FOR PURPOSES OF THE FEDERAL CROP INSURANCE ACT.—

“(1) IN GENERAL.—In the administration of section 506 of the Federal Crop Insurance Act, the Federal Crop Insurance Corporation may require each policyholder and each reinsured company to furnish to the insurer or to the Corporation the employer identification number of such policyholder, subject to the requirements of this paragraph. No officer or employee of the Federal Crop Insurance Corporation, or authorized person shall have access to any such number for any purpose other than the establishment of a system of records necessary to the effective administration of such Act. The Manager of the Corporation may require each policyholder to provide to the Manager or authorized person, at such times and in such manner as prescribed by the Manager, the employer identification number of each entity that holds or acquires a substantial beneficial interest in the policyholder. For purposes of this subclause, the term ‘substantial beneficial interest’ means not less than 5 percent of all beneficial interest in the policyholder. The Secretary of Agriculture shall restrict, to the satisfaction of the Secretary of the Treasury, access to employer identification numbers obtained pursuant to this paragraph only to officers and employees of the United States or authorized persons whose duties or responsibilities require access for the administration of the Federal Crop Insurance Act.

“(2) CONFIDENTIALITY AND NONDISCLOSURE RULES.—Employer identification numbers maintained by the Secretary of Agriculture or the Federal Crop Insurance Corporation pursuant to this subsection shall be confidential, and except as authorized by this subsection, no officer or employee of the United States or authorized person who has or had access to such employer identification numbers shall disclose any such employer identification number obtained thereby in any manner. For purposes of this paragraph, the term ‘officer or employee’ includes a former officer or employee. For purposes of this subsection, the term ‘authorized person’ means an officer or employee of an insurer whom the Manager of the Corporation designates by rule, subject to appropriate safeguards including a prohibition against the release of such social security account numbers (other than to the Corporations) by such person.

(4) the safety history associated with the transport of fertilizers, fuel, and pesticides by farmers and retail dealers and their employees; and

(5) the impact on rural communities, employment, and the cost and availability of fertilizer, fuel, and agricultural pesticides associated with complying with such Federal and State requirements.

(b) **REPORT.**—Not later than 18 months after the date of the enactment of this Act, the Secretary of Agriculture shall publish a report of such study and analyses (including comments on the adequacy of existing Federal and State requirements or exemptions) and submit the report to the appropriate committees of Congress.

(c) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of fulfilling the study, analyses, and reporting requirements under this section, there is authorized to be appropriated not more than \$75,000.

15 USC 714.

SEC. 2518. ESTABLISHING QUALITY AS A GOAL FOR COMMODITY CREDIT CORPORATION PROGRAMS.

In carrying out its activities the Commodity Credit Corporation shall, to the extent practicable, provide for program provisions that promote quality in the production and marketing of crops and livestock in the United States.

7 USC 1421 note.

SEC. 2519. SEVERABILITY.

If any provision of this Act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this Act which can be given effect without regard to the invalid provision or application, and to this end the provisions of this Act are severable.

Approved November 28, 1990.

LEGISLATIVE HISTORY—S. 2830 (H.R. 3581) (H.R. 3950) (H.R. 4077):

HOUSE REPORTS: No. 101-413 accompanying H.R. 4071 and No. 101-415 accompanying H.R. 3581 (both from Comm. on Agriculture); No. 101-569, Pt. 1 (Comm. on Agriculture), Pt. 2 (Comm. on Foreign Affairs), Pt. 3 (Comm. on Agriculture), Pt. 4 (Comm. on Education and Labor), and Pt. 5 (Comm. on Ways and Means), all accompanying H.R. 3950.

SENATE REPORTS: No. 101-357 (Comm. on Agriculture, Nutrition, and Forestry).
CONGRESSIONAL RECORD, Vol. 136 (1990):

Mar. 6, H.R. 4077 considered and passed House.

Mar. 14, 15, 22, H.R. 3581 considered and passed House.

July 19, 20, 23-27, S. 2830 considered and passed Senate.

July 23-25, 27, Aug. 1, H.R. 3950 considered and passed House.

Aug. 3, S. 2830 considered and passed House, amended, in lieu of H.R. 3581, H.R. 3950, and H.R. 4077.

Oct. 23, House agreed to conference report.

Oct. 25, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 26 (1990):

Nov. 28, Presidential remarks and statement.

FOOD AND AGRICULTURAL RESOURCES ACT OF 1990

JULY 18, 1990.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means,
submitted the following

REPORT

[To accompany H.R. 3950]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3950) entitled the "Food and Agricultural Resources Act of 1990", having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the reported bill) are as follows:

Page 2, strike out the entries in the table of contents for subtitle B of title II.

Page 2, in the entries for subtitle C of title II—

- (1) strike out "Subtitle C" and insert "Subtitle B",
- (2) redesignate section 231 as section 221, and
- (3) redesignate section 232 as section 222.

Page 2, insert before the entries for title III the following:

Subtitle C—Import Treatment of Sugars, Syrups, and Molasses

- Sec. 231. Findings and purpose.
- Sec. 232. Tariff treatment when tariff-rate quotas not in effect.
- Sec. 233. Tariff-rate quotas.
- Sec. 234. Applicable statutory authorities.
- Sec. 235. Definitions.
- Sec. 236. Conforming amendments to HTS.
- Sec. 237. Effective date; termination.

Page 9, after the entry for section 1493 in the table of contents insert the following:

PART 6—APPLICATION OF COMMODITY RESEARCH AND PROMOTION PROGRAMS TO IMPORTS

Sec. 1499. Consistency with international obligations of the United States.

Page 11, in the entries in the table of contents for subtitle G of title XVII—

animal husbandry, biotechnology; and that the boards and councils should pursue new food and nonfood uses for agricultural products developed through technological advances.

Explanation of Committee on Ways and Means amendment

The amendments approved by the Committee on Ways and Means make no change to section 1841 of the bill.

IV. FOOD STAMP PROGRAM: REQUIRED SUBMISSION OF SOCIAL SECURITY NUMBERS AND TAXPAYER IDENTIFICATION NUMBERS OF RETAIL FOOD STORES AND WHOLESALE FOOD CONCERNS

(Title XVII, Subtitle G, Section 1762)

Present Law

The nine digit social security number was created in 1935 for the sole purpose of recording and retrieving accurately the earnings records of workers. Over the years, the use of the social security number by the government has been expanded for two general purposes: 1) to enhance taxpayer compliance; and 2) to determine an individual's eligibility for Federal benefits.

With regard to the Food Stamp program, the Internal Revenue Code permits the Social Security Administration (SSA) to disclose certain tax return information to the Department of Agriculture and state food stamp agencies only for the purpose of determining an individual's eligibility for benefits or determining the amount of benefits an individual may receive.

Explanation of provision as reported by the Committee on Agriculture

The provision would require retail stores or wholesale food concerns applying to participate in the food stamp program to submit to the Secretary of Agriculture the social security numbers of the officers and on-site managers of each store.

Each retail store or wholesale food concern applying to participate in the food stamp program would be required to submit the taxpayer identification number of such store or concern.

Explanation of Committee on Ways and Means amendment

The provision would be deleted. The Committee believes that the Committee on Agriculture's provision to require all owners, officers and on-site managers of retail stores and wholesale food concerns to provide their social security number to the Secretary of Agriculture constitutes an inappropriate use of the social security number as an identifier. While most store owners and managers do benefit economically from operating a food stamp redemption center, they serve primarily as a vehicle through which the Federal government provides a benefit. Moreover, the Committee is reluctant to expand the role of the Social Security Administration to serve as an enforcement agent for other federal agencies.

The proposal contains no provision to safeguard the information provided by the individuals and does not limit the Department of Agriculture to specific uses of the social security numbers it would collect. In order for the Department of Agriculture to determine

that the names and numbers collected by the Secretary are accurate, the Social Security Administration would be asked to verify the information. This would place an additional burden on SSA's already limited resources. Furthermore, it is unclear that permitting the Secretary to collect the social security numbers of the owners, officers and on-site store managers will result in improved enforcement within the food stamp program. For these reasons, the Committee does not believe that the social security number should be used for the purpose recommended.

V. REPORTS AND STUDIES

A. Reports on quota allocations to countries importing sugar

(Title II, Subtitle C, Section 232)

Present law

Section 902(c) of the Food Security Act of 1985 prohibits the allocation of any U.S. sugar import quota to any country that is a net importer of sugar, unless the appropriate officials of such country verify to the President that such country does not import for re-export to the U.S. any sugar produced in Cuba.

Explanation of provision as reported by the Committee on Agriculture

Section 232 of H.R. 3950 as reported by the Committee on Agriculture amends the Food Security Act of 1985 to require the Secretary of Agriculture to report to the President and to the Congress, by August 1, of each year through 1995, the extent, if any, of Cuban sugar imports by countries which are net importers of sugar. This section further requires the President to report to the Congress by January 1 of each year, (1) the identity of countries that are net importers of sugar who hold a U.S. sugar import quota allocation, (2) the identity of countries who have verified that they do not import for re-export to the U.S. any sugar produced in Cuba, and (3) the action, if any, taken by the President with respect to countries reported by the Secretary of Agriculture as net importers of sugar who imported such sugar from Cuba and re-exported such sugar to the U.S. during the previous quota year.

Explanation of Committee on Ways and Means amendment

The amendments approved by the Committee on Ways and Means make no change to section 232.

B. Study of North American Free Trade Area

(Title XII, Subtitle D, Section 1231)

Present law

There is no provision of U.S. law requiring a study and report on the potential effects on the U.S. agricultural economy of the creation of a North American free trade area.

Finder's Aid
P.L. 101-649 (104 Stat. 4978) Approved November 29, 1990
Immigration Act of 1990

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>104 Stat.</u>	<u>H.Rep 101-187</u>	<u>H.Rep. 101-723 Part 1</u>	<u>H.C.Rep. 101-955</u>	<u>S.Rep. 101-55</u>
Old-Age and Survivors Insurance - Termination of Benefits Upon Deportation of Primary Beneficiary (conforming amendment)	202(n)	603(b)(5)(A)	5085	--	--	--	--
Old-Age and Survivors Insurance - Termination of Benefits Upon Deportation of Primary Beneficiary (conforming amendment)	202(n)	603(b)(5)(B)	5085	--	--	--	--
Supplemental Security Income - Meaning of Terms- Aged Blind, or Disabled Individual (conforming amendment)	1614(a)(1) (B)(i)	162(e)(5)	5011	--	134 9,	-- --	-- --

Public Law 101-649
101st Congress

An Act

Nov. 29, 1990
[S. 358]

To amend the Immigration and Nationality Act to change the level, and preference system for admission, of immigrants to the United States, and to provide for administrative naturalization, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Immigration Act
of 1990.
Passports and
visas.
8 USC 1101 note.

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Immigration Act of 1990”.

(b) **REFERENCES IN ACT.**—Except as specifically provided in this Act, whenever in this Act an amendment or repeal is expressed as an amendment to or repeal of a provision, the reference shall be deemed to be made to the Immigration and Nationality Act.

(c) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Sec. 1. Short title; references in Act; table of contents.

TITLE I—IMMIGRANTS

Subtitle A—Worldwide and Per Country Levels

Sec. 101. Worldwide levels.

Sec. 102. Per country levels.

Sec. 103. Treatment of Hong Kong under per country levels.

Sec. 104. Asylee adjustments.

Subtitle B—Preference System

PART 1—FAMILY-SPONSORED IMMIGRANTS

Sec. 111. Family-sponsored immigrants.

Sec. 112. Transition for spouses and minor children of legalized aliens.

PART 2—EMPLOYMENT-BASED IMMIGRANTS

Sec. 121. Employment-based immigrants.

Sec. 122. Changes in labor certification process.

Sec. 123. Definitions of managerial capacity and executive capacity.

Sec. 124. Transition for employees of certain United States businesses operating in Hong Kong.

PART 3—DIVERSITY IMMIGRANTS

Sec. 131. Diversity immigrants.

Sec. 132. Diversity transition for aliens who are natives of certain adversely affected foreign states.

Sec. 133. One-year diversity transition for aliens who have been notified of availability of NP-5 visas.

Sec. 134. Transition for displaced Tibetans.

Subtitle C—Commission and Information

Sec. 141. Commission on Legal Immigration Reform.

Sec. 142. Statistical information systems.

Subtitle D—Miscellaneous

Sec. 151. Revision of special immigrant provisions relating to religious workers (C special immigrants).

(B) by striking “a preference status under section 203(a)” and inserting “preference under subsection (a) or (b) of section 203”;

(3) in subsection (e), by striking “preference immigrant under section 203(a)” and inserting “immigrant under subsection (a), (b), or (c) of section 203”;

(4) in subsection (g)(1), by striking “203(a)(4)” and inserting “203(a)(3)”;

(5) by striking subsection (f); and

(6) by redesignating subsections (g) and (h) as (f) and (g), respectively.

(e) ADDITIONAL CONFORMING AMENDMENTS.—

(1) Section 212(a)(5) (8 U.S.C. 1182(a)(5)), as amended by section 601(a) of this Act, is amended—

(A) in subparagraph (A), by striking “Any alien who seeks to enter the United States for the purpose of performing skilled or unskilled labor” and inserting “Any alien who seeks admission or status as an immigrant under paragraph (2) or (3) of section 203(b)”;

(B) in subparagraph (B), by inserting “who seeks admission or status as an immigrant under paragraph (2) or (3) of section 203(b)” after “An alien” the first place it appears, and

(C) by striking subparagraph (C).

(2) Section 244(d) (8 U.S.C. 1254(d)) is amended by striking “, and unless” and all that follows through “then current”.

(3) Section 245(b) (8 U.S.C. 1255(b)) is amended—

(A) by striking “or nonpreference”,

(B) by striking “202(e) or 203(a)” and inserting “201(a)”, and

(C) by striking “for the fiscal year then current” and inserting “for the succeeding fiscal year”.

(4) Section 3304(a)(14)(A) of the Internal Revenue Code of 1986 is amended by striking “section 203(a)(7) or”. 26 USC 3304.

(5) Section 1614(a)(1)(B)(i) of the Social Security Act is amended by striking “section 203(a)(7) or”. 42 USC 1382c.

(6) Section 2(c)(4) of the Virgin Islands Nonimmigrant Alien Adjustment Act of 1982 (Public Law 97-271) is amended by inserting before the period at the end the following: “(as in effect before October 1, 1991) or by reason of the relationship described in section 203(a)(2), 203(a)(3), or 203(a)(4), or 201(b)(2)(A)(i), respectively, of such Act (as in effect on or after such date)”. 8 USC 1255 note.

(f) TECHNICAL CORRECTIONS TO IMMIGRATION NURSING RELIEF ACT OF 1989.—

(1) Section 2(b) of the Immigration Nursing Relief Act of 1989 (Public Law 101-238) is amended—

(A) by striking “December 31, 1989” and inserting “September 1, 1989”,

(B) by striking “in the lawful status” and inserting “in the status”,

(C) by inserting “unauthorized employment performed before the date of the enactment of the Immigration Act of 1990 shall not be taken into account in applying section 245(c)(2) of the Immigration and Nationality Act and” after “spouse or child of such an alien,” and

8 USC 1255 note.

and related grounds)” and by striking “; or” at the end and inserting a period; and

(E) by striking subclause (IV) of clause (iii).

(b) RELATING TO GROUNDS FOR DEPORTATION.—

(1) Section 210A(d)(5)(A) (8 U.S.C. 1161(d)(5)(A)) is amended by striking “241(a)(20)” and inserting “241(a)(1)(F)”

(2) Section 242 (8 U.S.C. 1252) is amended—

(A) in subsection (b), by striking “(4), (5), (6), (7), (11), (12), (14), (15), (16), (17), (18), or (19)” and inserting “(2), (3), or (4)”, and

(B) in subsection (e), by striking “paragraph (4), (5), (6), (7), (11), (12), (14), (15), (16), (17), (18), or (19)” and inserting “paragraph (2), (3) or (4)”.

(3) Sections 243(h)(1) and 244(a) (8 U.S.C. 1253(h)(1), 1254(a)) are each amended by striking “241(a)(19)” and inserting “241(a)(4)(D)”.

(4) Section 244 (8 U.S.C. 1254) is amended—

(A) in subsection (a)(2), by striking “paragraph (4), (5), (6), (7), (11), (12), (14), (15), (16), (17), or (18)” and inserting “paragraph (2), (3), or (4)”, and

(B) in subsection (e)(1), by striking “(4), (5), (6), (7), (11), (12), (14), (15), (16), (17), (18), or (19)” in paragraph (2) and inserting “(2), (3), or (4)”.

(5) Section 202(n) of the Social Security Act (42 U.S.C. 402(n)) is amended—

(A) by striking “paragraph (1), (2), (4), (5), (6), (7), (10), (11), (12), (14), (15), (16), (17), or (18) of section 241(a)” in paragraph (1) and inserting “under section 241(a) (other than under paragraph (1)(C) or (1)(E) thereof)”, and

(B) by striking “enumerated in paragraph (1) in this subsection” in paragraph (2) and inserting “(other than under paragraph (1)(C) or (1)(E) thereof)”

TITLE VII—MISCELLANEOUS PROVISIONS

SEC. 701. BATTERED SPOUSE OR CHILD WAIVER OF THE CONDITIONAL RESIDENCE REQUIREMENT.

(a) IN GENERAL.—Section 216(c)(4) (8 U.S.C. 1186a(c)(4)) is amended—

(1) by striking “or” at the end of subparagraph (A);

(2) in subparagraph (B), by striking “by the alien spouse for good cause”;

(3) in subparagraph (B), by striking the period at the end and inserting “, or”;

(4) by inserting after subparagraph (B) the following new subparagraph:

“(C) the qualifying marriage was entered into in good faith by the alien spouse and during the marriage the alien spouse or child was battered by or was the subject of extreme cruelty perpetrated by his or her spouse or citizen or permanent resident parent and the alien was not at fault in failing to meet the requirements of paragraph (1).”; and

(5) by adding at the end the following: “The Attorney General shall, by regulation, establish measures to protect the confidentiality of information concerning any abused alien spouse or

Regulations.

(2) the location of individuals in the United States requiring and desiring the educational assistance and training for which the funds can be applied, and

(3) the location of unemployed and underemployed United States workers.

(c) **DISBURSEMENT TO STATES.**—

(1) Within the purposes and allocations established under this section, disbursements shall be made to the States, in accordance with grant applications submitted to and approved jointly by the Secretaries of Labor and Education, to be applied in a manner consistent with the guidelines established by such Secretaries in consultation with the States. In applying such grants, the States shall consider providing funding to joint labor-management trust funds and other such non-profit organizations which have demonstrated capability and experience in directly training and educating workers.

(2) Not more than 5 percent of the funds disbursed to any State under this section may be used for administrative expenses.

(d) **LIMITATION ON FEDERAL OVERHEAD.**—The Secretaries shall provide that not more than 2 percent of the amount of funds disbursed to States under this section may be used by the Federal Government in the administration of this section.

(e) **ANNUAL REPORT.**—The Secretary of Labor shall report annually to the Congress on the grants to States provided under this section.

(f) **STATE DEFINED.**—In this section, the term “State” has the meaning given such term in section 101(a)(36) of the Immigration and Nationality Act.

Approved November 29, 1990.

LEGISLATIVE HISTORY—S. 358 (H.R. 1630) (H.R. 4300):

HOUSE REPORTS: No. 101-187 accompanying H.R. 1630 (Comm. on the Judiciary); No. 101-723, Pt. 1 (Comm. on the Judiciary) and Pt. 2 (Comm. on Ways and Means) both accompanying H.R. 4300; and No. 101-955 (Comm. of Conference).

SENATE REPORTS: No. 101-55 (Comm. on the Judiciary).

CONGRESSIONAL RECORD:

Vol. 135 (1989): July 11-13, considered and passed Senate.

July 31, H.R. 1630 considered and passed House.

Vol. 136 (1990): Oct. 2, 3, H.R. 4300 considered and passed House; S. 358, amended, passed in lieu.

Oct. 26, Senate agreed to conference report.

Oct. 27, House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 26 (1990):

Nov. 29, Presidential remarks and statement.

FAMILY UNITY AND EMPLOYMENT OPPORTUNITY IMMIGRATION ACT OF 1990

SEPTEMBER 19, 1990.—Ordered to be printed

Mr. BROOKS, from the Committee on the
Judiciary, submitted the following

REPORT

together with

DISSENTING VIEWS

[To accompany H.R. 4300]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 4300) to amend the Immigration and Nationality Act to revise the system of admission of aliens on the basis of family reunification and to meet identified labor shortages, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE: TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Family Unity and Employment Opportunity Immigration Act of 1990”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—FAMILY-SPONSORED AND EMPLOYMENT-BASED IMMIGRATION

SUBTITLE A—ADMISSION AND STATUS

- Sec. 101. Separate levels for family-sponsored and employment-based immigration.
- Sec. 102. Preference system for admission of immigrants.
- Sec. 103. Labor attestation process.
- Sec. 104. Nonimmigrant classifications.
- Sec. 105. Admission of aliens in religious occupations.
- Sec. 106. Denial of crewmember status in the case of certain labor disputes.
- Sec. 107. Effective dates; transition.

SUBTITLE B—EDUCATION AND TRAINING OF AMERICAN WORKERS

- Sec. 111. Fees for admission of certain employment-based aliens.
- Sec. 112. Educational assistance and training.
- Sec. 113. Higher education scholarship program for mathematics and sciences.

TITLE II—OTHER PROVISIONS REGARDING IMMIGRANT VISAS

- Sec. 201. Transition for aliens who are natives of certain adversely affected foreign states.
- Sec. 202. Transition for certain displaced aliens.
- Sec. 203. Transition for African immigrants.
- Sec. 204. Backlog visa numbers for second and fifth preferences.
- Sec. 205. Transition for third and sixth preference.
- Sec. 206. Transition for employees of certain United States businesses operating in Hong Kong.
- Sec. 207. Treatment of Hong Kong as separate foreign state for numerical limitation purposes.
- Sec. 208. Permitting extension of period of validity of immigrant visas for certain residents of Hong Kong.

TITLE III—OTHER IMMIGRATION PROVISIONS

SUBTITLE A—PROVISIONS RELATING TO MARRIAGE FRAUD

- Sec. 301. Battered spouse or child waiver of the conditional residence requirement.
- Sec. 302. Bona fide marriage exception to foreign residence requirement for marriages entered into during certain immigration proceedings.

SUBTITLE B—PROVISIONS RELATING TO IMMIGRATION REFORM AND CONTROL ACT OF 1986

- Sec. 311. Application of employer sanctions to longshore work.
- Sec. 312. Elimination of paperwork requirement for recruiters and referrers.
- Sec. 313. Permitting court-ordered remedies in certain circumstances.
- Sec. 314. Prohibition of deportation of spouses and children of legalized aliens.
- Sec. 315. Treatment of certain legalization applicants.
- Sec. 316. Reimbursement through Immigration Emergency Fund of localities impacted by increases in aliens applying for asylum.
- Sec. 317. Clarification of authorization of appropriations for the Immigration Emergency Fund.

SUBTITLE C—MISCELLANEOUS

- Sec. 321. Special immigrant status for certain aliens declared dependent on a juvenile court.
- Sec. 322. Statistical information system.
- Sec. 323. Revision of health grounds for exclusion.
- Sec. 324. Waiver of English language requirement for naturalization.
- Sec. 325. Treatment of service in armed forces of a foreign country.

TITLE I—FAMILY-SPONSORED AND EMPLOYMENT-BASED IMMIGRATION

SUBTITLE A—ADMISSION AND STATUS

SEC. 101. SEPARATE LEVELS FOR FAMILY-SPONSORED AND EMPLOYMENT-BASED IMMIGRATION.

(a) **IN GENERAL.**—Section 201 of the Immigration and Nationality Act (8 U.S.C. 1151) is amended to read as follows:

“WORLDWIDE LEVEL OF IMMIGRATION

“SEC. 201. (a) **IN GENERAL.**—Exclusive of aliens described in subsection (b), aliens born in a foreign state or dependent area who may be issued immigrant visas or who may otherwise acquire the status of an alien lawfully admitted to the United States for permanent residence are limited to—

“(1) family-sponsored immigrants described in section 203(a) (or who are admitted under section 211(a) on the basis of a prior issuance of a visa to their accompanying parent under section 203(a)) in a number not to exceed in any fiscal year 185,000 and not to exceed in any of the first 3 quarters of any fiscal year 27 percent of the worldwide level under this paragraph for all of such fiscal year;

“(2) employment-based immigrants described in section 203(b) (or who are admitted under section 211(a) on the basis of a prior issuance of a visa to their accompanying parent under section 203(b)), in a number not to exceed 65,000 in each of fiscal years 1992 through 1996, and not to exceed 75,000 in each fiscal year thereafter and not to exceed in any of the first 3 quarters of any fiscal year 27 percent of the worldwide level under this paragraph for all of such fiscal year; and

“(3) for fiscal years beginning with fiscal year 1994, diversity immigrants described in section 203(c) (or who are admitted under section 211(a) on the basis of a prior issuance of a visa to their accompanying parent under section 203(c)) in a number not to exceed 55,000 in each fiscal year and not to exceed in any of the first 3 quarters of any fiscal year 27 percent of the worldwide level under this paragraph for all of such fiscal year.

“(b) **ALIENS NOT SUBJECT TO NUMERICAL LIMITATIONS.**—The following aliens are not subject to the worldwide levels or numerical limitations of subsection (a):

“(1)(A) Special immigrants described in section 101(a)(27).

preference immigrant aliens described in section 203(a)(7)" and inserting "preference immigrant aliens described in section 203(b)(2)".

(3) Section 245(b) of such Act (8 U.S.C. 1255(b)) is amended—

(A) by striking "or nonpreference",

(B) by striking "202(e) or 203(a)" and inserting "201(a)", and

(C) by striking "for the fiscal year then current" and inserting "for the succeeding fiscal year".

(4) Section 3304(a)(14)(A) of the Internal Revenue Code of 1986 is amended by striking "section 203(a)(7) or".

(5) Section 1614(a)(1)(B)(i) of the Social Security Act is amended by striking "section 203(a)(7) or".

(f) Technical Corrections to Immigration Nursing Relief Act of 1989.—

(1) Section 2 of the Immigration Nursing Relief Act of 1989 (Public Law 101-238) is amended—

(A) in subsection (a)—

(i) by striking ", and the immigrant's accompanying spouse and children", and

(ii) by inserting after the first sentence the following:

"Such numerical limitations also shall not apply to the adjustment of status of, or issuance of an immigrant visa to, the immigrant's spouse and children if accompanying or following to join the immigrant."; and

(B) in subsection (b)—

(i) by striking "December 31, 1989" and inserting "September 1, 1989",

(ii) by striking "in the lawful status" and inserting "in the status",

(iii) by inserting "unauthorized employment performed before the date of the enactment of the Family Unity and Employment Opportunity Immigration Act of 1990 shall not be taken into account in applying section 245(c)(2) of the Immigration and Nationality Act and" after "spouse or child or such an alien," and

(iv) by striking "lawful status as such a nonimmigrant" and all that follows through "subsection (a)" and inserting "lawful status throughout his or her stay in the United States as a nonimmigrant until the end of the 120-day period beginning on the date the Attorney General promulgates regulations carrying out the amendments made by section 102(f)(1)(A) of the Family Unity and Employment Opportunity Immigration Act of 1990".

(2) The amendments made by paragraph (1) shall apply as though included in the enactment of the Immigration Nursing Relief Act of 1989.

SEC. 103. LABOR ATTESTATION PROCESS.

(a) IN GENERAL.—Section 212(a)(14) of the Immigration and Nationality Act (8 U.S.C. 1182(a)(14)) is amended to read as follows:

"(14) Aliens seeking admission or status as an immigrant under section 203(b)(2) or as a nonimmigrant under section 101(a)(15)(H)(i)(b) or 101(a)(15)(H)(ii)(b) unless with respect to the aliens the Secretary of Labor certifies to the Secretary of State and the Attorney General that an attestation is on file and in effect under section 212(n) for the employer and occupational classification for which the alien will perform services;"

(b) USE OF ATTESTATIONS.—Section 212 of such Act, as amended by section 3(b) of Public Law 101-238, is amended by adding at the end the following new subsection:

"(n)(1) The attestation referred to in subsection (a)(14), with respect to an alien who is coming to the United States to be employed by an employer in an occupational classification, is an attestation as to the following:

"(A) Subject to paragraph (3), the employer—

"(i)(I) has made and is making positive recruitment efforts, in the recruitment area identified under paragraph (2)(A), reasonably designed to locate and employ able, willing, and qualified (or equally qualified in the case of aliens who are members of the teaching profession or who have exceptional ability in the sciences or the arts) workers, and

"(II) recites the specific actions the employer has taken with respect to such recruitment; and

"(ii) has been unable to find such workers who are available at the time and place of need.

"(B) The employer is offering and will offer (in the case of a nonimmigrant under section 101(a)(15)(H)(i)(b) or 101(a)(15)(H)(ii)(b), during the period of authorized employment or, in the case of an immigrant under section 203(b)(2),

(1) shall be available for reimbursement of localities that have provided assistance to aliens in that district who have asylum applications pending.

(B) Not more than \$20,000,000 shall be made available for all localities under this paragraph.

* * * * *

SECTION 3304 OF THE INTERNAL REVENUE CODE OF 1986

SEC. 3304. APPROVAL OF STATE LAWS.

(a) REQUIREMENTS.—The Secretary of Labor shall approve any State law submitted to him, within 30 days of such submission, which he finds provides that—

(1) * * *

* * * * *

(14)(A) compensation shall not be payable on the basis of services performed by an alien unless such alien is an individual who was lawfully admitted for permanent residence at the time such services were performed, was lawfully present for purposes of performing such services, or was permanently residing in the United States under color of law at the time such services were performed (including an alien who was lawfully present in the United States as a result of the application of the provisions of [section 203(a)(7) or] section 212(d)(5) of the Immigration and Nationality Act),

* * * * *

SECTION 1614 OF THE SOCIAL SECURITY ACT

MEANING OF TERMS

Aged, Blind, or Disabled Individual

SEC. 1614. (a)(1) For purposes of this title, the term “aged, blind, or disabled individual” means an individual who—

(A) * * *

(B)(i) is a resident of the United States, and is either (I) a citizen or (II) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of [section 203(a)(7) or] section 212(d)(5) of the Immigration and Nationality Act), or

* * * * *

SECTION 2 OF THE IMMIGRATION NURSING RELIEF ACT OF 1989

SEC. ADJUSTMENT OF STATUS FOR CERTAIN H-1 NONIMMIGRANT NURSES.

(a) IN GENERAL.—The numerical limitation of sections 201 and 202 of the Immigration and Nationality Act shall not apply to the adjustment of status under section 245 of such Act of an immi-

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